Mass Shootings at Virginia Tech

Addendum to the Report of the Review Panel

Presented to:

Governor Timothy M. Kaine
Commonwealth of Virginia

November 2009

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Commonwealth of Virginia

Presented by:

TriData Division, System Planning Corporation
3601 Wilson Boulevard
Arlington, VA 22201

November 2009
(revised December 2009)

INTRODUCTION

On April 16, 2007, Virginia Tech experienced one of the most horrific events in American university history—a double homicide followed by a mass shooting that left 32 students and faculty killed, with many others injured, and many more scarred psychologically. Families of the slain and injured as well as the university community have suffered terribly.

Immediately after the incident Virginia Governor Timothy M. Kaine created a blue ribbon Review Panel, referred to as the Virginia Tech Review Panel, which consisted of nine members selected for their expertise in the areas that were to be investigated. The Review Panel's mission was to assess the events leading to the shooting and how the incident was handled by the university and public safety agencies. Mental health services and privacy laws were examined as well. The Review Panel was to make recommendations that would help college campuses prevent or mitigate such incidents in the future. The Report of the Review Panel was presented to the Governor in late August 2007. It is referred to as the "Report" in this Addendum.

SCOPE OF THIS REPORT: ADDITIONS AND CORRECTIONS

In the two years since the Review Panel's report was published, additional information has been placed in the public record, including Seung Hui Cho's case file from the Cook Counseling Center and a recent report from the Commonwealth's Inspector General concerning the Cook Counseling Center's handling of Cho's records. Briefings to the victims' families by police and Virginia Tech officials provided additional details of the events

In light of the new information presented to the families, and other information they found in the April 16 archive, several family members requested that additions and corrections be made to the Report. Some families had personal knowledge of the events that were not previously shared. Some families requested new interpretations of certain findings or revisions to some of the Review Panel's recommendations in light of the new information. Virginia Tech officials also submitted comments requesting some corrections.

Governor Kaine asked the victims' families and Virginia Tech to submit any corrections or additions they thought important by the end of August, 2009. The time was extended into September after discovery of Cho's missing Cook Counseling Center records.

This Addendum responds to the comments and questions received from the families and Virginia Tech by correcting facts in the original report, including the timeline, and by adding additional information about the events leading to the incidents, the response to the incidents, and the aftermath of April 16. The Addendum also includes corrections to names and titles of people cited in the Report or the list of interviewees. The Addendum does not address opinions or value judgments that were raised, but provides some additional background information that might help address the concerns raised.

ADDENDUM PROCESS

Governor Kaine engaged the TriData staff that supported the Review Panel to review the additional information and the questions and comments about the Report. TriData was familiar with the research and details of the Report, the sources, and the deliberations behind the Report's original findings and recommendations. All comments received by the Governor's Office were forwarded to TriData for review.

The focus of this Addendum is on correcting and adding to the pertinent facts. Many of the families as well as Virginia Tech submitted corrections or comments and added detailed references to documents now in the public record. After completing an initial review of the comments from all parties, TriData submitted a number of questions to Virginia Tech and also interviewed several family members for clarification of their comments, and to cross-check information and corroborate facts.

There are conflicting opinions on whether the Review Panel should have treated certain issues differently, reached stronger or different conclusions, placed blame on certain individuals, or interviewed additional people. The new and additional information has tended to reinforce the Review Panel's original findings and recommendations. In several instances, emphasis was added to findings where strongly supported by the facts. While some of the findings have been modified slightly and one added, none of the new information merited changes to any of the recommendations in the original Report.

A number of questions and corrections were raised about the timeline in the Report. The timeline was intended to provide an overview of the most important markers in the sequence of events to assist readers as a reference as they went through the details in the text. The Review Panel chose not to include many details in the timeline that were later discussed in the text. This Addendum contains an expanded timeline with virtually all of the additions suggested by the families.

CLARIFICATION AND CORRECTION OF ADDENDUM

This Addendum was shown to the families of victims, Virginia Tech, and the Review Panel the day before it was published. To maintain independence of the findings they were not asked to review the changes made. Many of the changes but not all had been discussed with various people in these groups, and most of the changes came from comments they had submitted to the Governor, as noted above. Nevertheless, after the initial publication of the Addendum a few errors or unclear points were reported, and they are corrected in this version.

SCOPE OF ORIGINAL REVIEW PANEL REPORT

As described in the Review Panel's Report, Governor Kaine's executive order directed the Review Panel to accomplish the following:

1. "Conduct a review of how Seung Hui Cho committed these 32 murders and multiple additional woundings, including without limitation how he obtained his firearms and ammunition, and to learn what can be learned about what caused him to commit these acts of violence."

2. "Conduct a review of Seung Hui Cho's psychological condition and behavioral issues prior to and at the time of the shootings, what behavioral aberrations or potential warning signs were observed by students, faculty and/or staff at Westfield High School and Virginia Tech. This inquiry should include the response taken by Virginia Tech and others to note psychological and behavioral issues, Seung Hui Cho's interaction with the mental health delivery system, including without limitation judicial intervention, access to services, and communication between the mental health services system and Virginia Tech. It should also include a review of educational, medical, and judicial records documenting his condition, the services rendered to him, and his commitment hearing."

3. "Conduct a review of the timeline of events from the time that Seung Hui Cho entered West Ambler Johnston Dormitory until his death in Norris Hall. Such review shall include an assessment of the response to the first murders and efforts to stop the Norris Hall murders once they began."

4. "Conduct a review of the response of the Commonwealth, all of its agencies, and relevant local and private providers following the death of Seung Hui Cho for the purpose of providing recommendations for the improvement of the Commonwealth's response in similar emergency situations. Such review shall include an assessment of the emergency medical response provided for the injured and wounded, the conduct of post-mortem examinations and release of remains, on-campus actions following the tragedy, and the services and counseling offered to the victims, the victims' families, and those affected by the incident. In so doing, the Review Panel shall to the extent required by federal or state law: (i) protect the confidentiality of any individual's or family member's personal or health information; and (ii) make public or publish information and findings only in summary or aggregate form without identifying personal or health information related to any individual or family member unless authorization is obtained from an individual or family member that specifically permits the Review Panel to disclose that person's personal or health information."

5. "Conduct other inquiries as may be appropriate in the Review Panel's discretion otherwise consistent with its mission and authority as provided herein."

6. "Based on these inquiries, make recommendations on appropriate measures that can be taken to improve the laws, policies, procedures, systems and institutions of the Commonwealth and the operation of public safety agencies, medical facilities, local agencies, private providers, universities, and mental health services delivery system."

"In summary, the Review Panel was tasked to review the events, assess actions taken and not taken, identify lessons learned, and propose alternatives for the future. Included a review of Cho's history and interaction with the mental health and legal systems and of his gun purchases. The Review Panel was also asked to review the emergency response by all parties (law enforcement officials, university officials, medical responders and hospital care providers, and the Medical Examiner). Finally, the Review Panel reviewed the aftermath—the university's approach to helping families, survivors, students, and staff as they dealt with the mental trauma and the approach to helping the university heal itself and function again."

REVIEW PANEL AND STAFF

The Review Panel consisted of nine highly distinguished members from a variety of relevant backgrounds. Members included a former Governor and Secretary of the U.S. Department of Homeland Security, a judge, a psychiatrist, a professor of emergency medicine, a former FBI official who established the FBI's Center for the Analysis of Violent Crime, a former head of the Virginia State Police, a specialist in university administration, and a specialist in assisting families of crime victims. The Review Panel members volunteered their time for the four-month study period.

The Review Panel was supported by staff from the TriData Division, System Planning Corporation of Arlington, Virginia. SPC/TriData specializes in public safety consulting and research, and had undertaken over 50 studies of major disasters to identify the lessons learned. One of those studies reported on the lessons learned from the Columbine High School shootings. These studies were directed by the two TriData managers, Philip Schaenman and Hollis Stambaugh,

who served as the Review Panel staff director and deputy director respectively. TriData also completed a review for FEMA of the Northern Illinois University mass shooting and authored this Addendum.

REVIEW PANEL PROCESS AND CONSTRAINTS

Among questions received from the victims' families was a request for additional information about how the Review Panel approached the investigation into the shooting and arrived at their conclusions, and why certain information was or was not included. Thus, it may be useful to review the process and the constraints within which the Review Panel worked.

Time Constraints – Governor Kaine directed the Review Panel to complete its review of the Virginia Tech shootings before classes resumed the next semester. This meant that the Report had to be published by late August 2007, four months after starting. (Elements of the review started the week immediately following the shooting) The Governor felt it was important to identify any campus safeguards or executive orders needed before students returned to classes at Virginia Tech and other schools across the state. It also was important to identify any changes needed in state legislation with adequate time before the next session of the state legislature. For the families, the Virginia Tech community, and general public, it was important to produce information as soon as possible on the events of April 16.

The Review Panel would have liked to have had more time to interview additional people and to delve further into certain details. However, all understood the importance of getting the main facts and the big picture correct and out to the public as soon as possible. The Review Panel used its best judgment on what to cover in the available time in light of the many issues that were found across many disciplines. As noted above, additional information has become available since the Report was released. The victims' families and Virginia Tech have closely evaluated the Report in light of the new information and have submitted comments to the Governor. These have been thoroughly studied and this Addendum is the product of that work. While some details are added and some corrected, all the original recommendations remain valid.

Authority – The Review Panel benefited from the Governor's authority to collect information but it did not have subpoena power. State and local police and the FBI provided briefings to the Review Panel, but the Panel did not have access to the police investigation files. The police subsequently provided a briefing to the victims' families and that information has been included in this Addendum.)

Breadth of Interviews – In the course of carrying out the Governor's directive, the Review Panel interviewed over 200 individuals, heard presentations from many experts, and listened to comments from the victims' families and the general public at four public hearings held throughout the state. In addition, thousands of other people sent information, opinions, and suggestions to a special website established for that purpose.

The interviewees included many faculty, students, injured victims, victims' families, law enforcement personnel, emergency medical service providers, hospital emergency room personnel, personnel from the Office of the Medical Examiner and the Office of Victim Services, Virginia Tech officials, the Virginia Commissioner of Mental Health and personnel from the Virginia Attorney General's office. Review Panel members also interviewed Cho's family and various health practitioners who had treated him as well as individuals from his high school, including his high school guidance counselor.

Four public hearings were held to help gather information and views from selected key individuals who were close to the events. The Review Panel invited experts in various relevant areas such as university counseling, police procedures, firearm regulations, and mental health to make presentations. Time for public comment was provided at the close of each meeting. Victims' families were present throughout the hearings.

Discretion on Details Included – In addition to interviews, presentations of experts and public hearings, the Review Panel examined and discussed over 1,000 pages of documents. The Review Panel felt it was neither possible nor desirable to publish every fact collected and the Review Panel used its discretion in determining the most relevant information to include in the Report. The Review Panel began by including details of Cho's personal history and the actions taken and decisions made by Virginia Tech and law enforcement on April 16 and then concluded with its findings of what improvements should be made. The Review Panel wanted to avoid obfuscating the major findings in a cloud of lesser important or repetitive details, focusing on the findings and recommendations that were key to improving campus safety. For example, Cho had been a student in over 35 different classes and had written some disturbing material for several English Department faculty members, but only a representative few of his professors were mentioned and only a few of his papers were cited as examples in the Report.

The Review Panel held several 10 and 12-hour Review Panel work sessions in which Review Panel members painstakingly evaluated and discussed the assembled information and drafted recommendations supported by the research.

Independence – The Review Panel operated independently from both Virginia Tech and the Office of the Governor, though numerous Virginia Tech and Commonwealth employees were interviewed during the review. The Report's findings and recommendations were solely those of the Review Panel.

To preserve the Report's objectivity, neither Virginia Tech nor the families of the victims were permitted to comment on drafts of the Report before publication. Families of victims, however, were briefed on the major findings and the nature of the research during the review process.

ORGANIZATION OF THIS ADDENDUM

Following this introduction are all sections of the original Report and Appendix B. This Addendum presents additions and corrections at the end of each chapter. The additions and corrections are organized by page number of the Report to which the issue was directed. Subject headings and some context are provided to make the corrections self-standing without need to reference the text. A revised timeline is included with additional details and corrections to the original timeline.

A revised interviewee list (Appendix B in the original Report) indicates corrections to names and positions, and some personal preferences expressed to us from some interviewees of how they wished their names to be listed. Some other desired changes to names and descriptions are included in the revised Dedication section.

Specific questions or comments have not been attributed to individuals in order to preserve confidentiality. All comments and concerns submitted to the Governor's office by families and Virginia Tech were reviewed and addressed. In some cases extensive research failed to substantiate a suggested change, but most of the factual comments resulted in changes or clarifications. Comments appear immediately following the corrections and additions on other issues raised that had incorrect factual basis or that missed some information in the Report.

The original Report continues to stand as it was written by the Review Panel. The Review Panel worked hard on crafting the language of its Report and on reaching consensus on its findings and recommendations. The primary intent of this Addendum is to correct the factual record, both for future understanding of the terrible events of April 16, 2007, and to honor and respect those who died or suffered from the attacks.

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DEDICATION

The Virginia Tech Review Panel invited the families of the victims to lend their words as a dedication of this report. The panel is honored to share their words of love, remembrance, and strength.

* * *

We dedicate this report not solely to those who lost their lives at Virginia Tech on April 16, 2007, and to those physically and/or psychologically wounded on that dreadful morning, but also to every student, teacher, and institution of learning, that we may all safely fulfill our goals of learning, educating, and enriching humanity's stores of knowledge: the very arts and sciences that ennoble us.*

"Love does not die, people do. So when all that is left of me is love... Give me away..." – *John Wayne Schlatter*

"This is the beginning of a new day. You have been given this day to use as you will. You can waste it or use it for good. What you do today is important because you are exchanging a day of your life for it. When tomorrow comes, this day will be gone forever; in its place is something that you have left behind...let it be something good." – *Anonymous*

"We should consider every day lost on which we have not danced at least once. And we should call every truth false which was not accompanied by at least one laugh." – *Friedrich Nietzsche*

"Unable are the loved to die, for Love is Immortality." – *Emily Dickinson*

32 candles burning bright for all to see,
Lifting up the world for peace and harmony,
Those of us who are drawn to the lights,
enduringly embedded in our mind, indelibly
ingrained on our heart, forever identifying our spirit,
We call out your name:
Erin, Ryan, Emily, Reema, Daniel, Matthew, Kevin, Brian, Jarrett, Austin, Henry, Liviu, Nicole, Julia, Lauren, Partahi, Jamie, Jeremy, Rachel, Caitlin, Maxine, Jocelyne, Leslie, Juan, Daniel, Ross, G.V., Mary, Matthew, Minal, Michael, Waleed,
and,
hold these truths ever so tight,
your lives have great meaning, your lives have great power, your lives will *never* be forgotten, YOU will *always* be remembered,
–never and always...

– *Pat Craig*

*Neither this dedication nor the use herein of the victims' photos or bios represents an endorsement of the report by the victims' families.

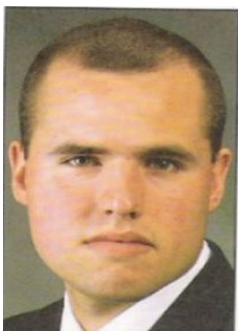
DEDICATION

Ross A. Alameddine
Hometown: Saugus, Massachusetts
Sophomore, University Studies
Student since fall 2005

Posthumous degree:
Bachelor of Arts, English and Foreign Languages/French

Ryan Christopher Clark
Hometown: Martinez, Georgia
Senior, Psychology
Student since fall 2002

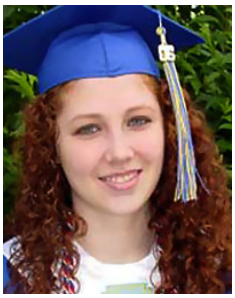
Posthumous degrees:
Bachelor of Science, Biological Sciences
Bachelor of Arts, English
Bachelor of Science, Psychology



Matthew Gregory Gwaltney
Hometown: Chesterfield, Virginia
Masters student, Environmental Engineering
Student since fall 2001

Posthumous degree:
Master of Science, Environmental Engineering

Christopher James Bishop
Residence in Blacksburg
Instructor, Foreign Languages
Joined Virginia Tech on
August 10, 2005



Austin Michelle Cloyd
Hometown: Blacksburg, Virginia
Sophomore, Honors Program, International Studies
Student since fall 2006

Posthumous degrees:
Bachelor of Arts, Foreign Languages/French
Bachelor of Arts, International Studies

Caitlin Millar Hammaren
Hometown: Westtown, New York
Sophomore, International Studies
Student since fall 2005

Posthumous degree:
Bachelor of Arts, International Studies

Brian Roy Bluhm
Hometown: Cedar Rapids, Iowa
Masters student, Civil Engineering
Student since fall 2000

Posthumous degree:
Master of Science, Civil Engineering

Kevin P. Granata
Residence in Blacksburg
Professor, Engineering Science and Mechanics
Joined Virginia Tech on
January 10, 2003

Jeremy Michael Herbstritt
Hometown: Blacksburg, Virginia
Masters student, Civil Engineering
Student since fall 2006

Posthumous degree:
Master of Science, Civil Engineering

DEDICATION

Rachael Elizabeth Hill
Hometown: Glen Allen, Virginia
Freshman, University Studies
Student since fall 2006

Posthumous degree:
Bachelor of Science, Biological Sciences

Emily Jane Hilscher
Hometown: Woodville, Virginia
Freshman, Animal and Poultry Sciences
Student since fall 2006

Posthumous degree:
Bachelor of Science, Animal and Poultry Sciences

Partahi Mamora Halomoan Lumbantoruan
Hometown: Blacksburg, Virginia (originally from Indonesia)
Ph.D. student, Civil Engineering
Student since fall 2003

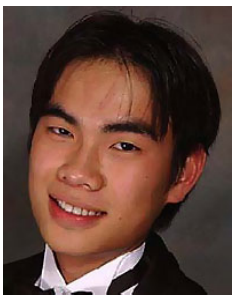
Posthumous degree:
Doctor of Philosophy, Civil Engineering

Jarrett Lee Lane
Hometown: Narrows, Virginia
Senior, Civil Engineering
Student since fall 2003

Posthumous degree:
Bachelor of Science, Civil Engineering

Matthew Joseph La Porte
Hometown: Dumont, New Jersey
Sophomore, University Studies
Student since fall 2005

Posthumous degree:
Bachelor of Arts, Political Science



Henry J. Lee
Hometown: Roanoke, Virginia
Sophomore, Computer Engineering
Student since fall 2006

Posthumous degree:
Bachelor of Science, Computer Engineering

Liviu Librescu
Residence in Blacksburg
Professor, Engineering Science and Mechanics
Joined Virginia Tech on
September 1, 1985

G. V. Loganathan
Residence in Blacksburg
Professor, Civil and Environmental Engineering
Joined Virginia Tech on
December 16, 1981

Lauren Ashley McCain
Hometown: Hampton, Virginia
Freshman, International Studies
Student since fall 2006

Posthumous degree:
Bachelor of Arts, International Studies

DEDICATION

Jocelyne Couture-Nowak
Residence in Blacksburg
Adjunct Professor, Foreign Languages
Joined Virginia Tech on
August 10, 2001

Daniel Patrick O'Neil
Hometown: Lincoln, Rhode Island
Masters student, Environmental Engineering
Student since fall 2006

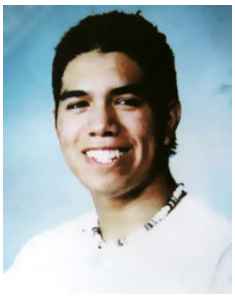
Posthumous degree:
Master of Science, Environmental Engineering

Juan Ramon Ortiz-Ortiz
Hometown: Blacksburg, Virginia
Masters student, Civil Engineering
Student since fall 2006

Posthumous degree:
Master of Science, Civil Engineering

Minal Hiralal Panchal
Hometown: Mumbai, India
Masters student, Architecture
Student since fall 2006

Posthumous degree:
Master of Science, Architecture

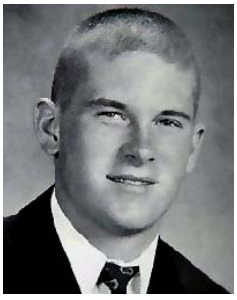


Daniel Alejandro Perez
Hometown: Woodbridge, Virginia
Sophomore, International Studies
Student since summer 2006

Posthumous degree:
Bachelor of Arts, International Studies

Erin Nicole Peterson
Hometown: Centreville, Virginia
Freshman, International Studies
Student since fall 2006

Posthumous degree:
Bachelor of Arts, International Studies



Michael Steven Pohle, Jr.
Hometown: Flemington, New Jersey
Senior, Biological Sciences
Student since fall 2002

Posthumous degree:
Bachelor of Science, Biological Sciences

Julia Kathleen Pryde
Hometown: Blacksburg, Virginia
Masters student, Biological Systems Engineering
Student since fall 2001

Posthumous degree:
Master of Science, Biological Systems Engineering

Mary Karen Read
Hometown: Annandale, Virginia
Freshman, Interdisciplinary Studies
Student since fall 2006

Posthumous degree:
Bachelor of Arts, Interdisciplinary Studies

Reema Joseph Samaha
Hometown: Centreville, Virginia
Freshman, University Studies
Student since fall 2006

Posthumous degrees:
Bachelor of Arts, International Studies
Bachelor of Arts, Public and Urban Affairs

Waleed Mohamed Shaalan
Hometown: Blacksburg, Virginia (originally from Egypt)
Ph.D. student, Civil Engineering
Student since fall 2006

Posthumous degree:
Doctor of Philosophy, Civil Engineering

Leslie Geraldine Sherman
Hometown: Springfield, Virginia
Junior, Honors Program, History
Student since fall 2005

Posthumous degrees:
Bachelor of Arts, History
Bachelor of Arts, International Studies

Maxine Shelly Turner
Hometown: Vienna, Virginia
Senior, Honors Program, Chemical Engineering
Student since fall 2003

Posthumous degree: Bachelor of Science, Chemical Engineering

Nicole Regina White
Hometown: Smithfield, Virginia
Sophomore, International Studies
Student since fall 2004

Posthumous degree:
Bachelor of Arts, International Studies

ADDITIONS AND CORRECTIONS

Two of the above write-ups on the victims have had changes made as requested by their families.

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FOREWORD

From Timothy M. Kaine
Governor, Commonwealth Of Virginia

On April 16, 2007, a tragic chapter was added to Virginia's history when a disturbed young man at Virginia Tech took the lives of 32 students and faculty, wounded many others, and killed himself. In the midst of unspeakable grief, the Virginia Tech community stood together, with tremendous support from friends in all corners of the world, and made us proud to be Virginians.

Over time, the tragedy has been felt by all it touched, most deeply by the families of those who were killed and by the wounded survivors and their families. The impact has been felt as well by those who witnessed or responded to the shooting, the broad Virginia Tech community, and those who are near to Blacksburg geographically or in spirit.

In the days immediately after the shooting, I knew it was critical to seek answers to the many questions that would arise from the tragedy. I also felt that the questions should be addressed by people who possessed both the expertise and autonomy necessary to do a comprehensive review. Accordingly, I announced on April 19 the formation of the Virginia Tech Review Panel to perform a review independent of the Commonwealth's own efforts to respond to the terrible events of April 16. The Panel members readily agreed to devote time, expertise, and emotional energy to this difficult task.

Those who agreed to serve were:

- Panel Chair Col. Gerald Massengill, a retired Virginia State Police Superintendent who led the Commonwealth's law enforcement response to the September 11, 2001, attack on the Pentagon and the sniper attacks that affected the Commonwealth in 2002.
- Panel Vice Chair Dr. Marcus L. Martin, Professor of Emergency Medicine, Assistant Dean of the School of Medicine and Associate Vice President for Diversity and Equity at the University of Virginia.
- Gordon Davies, former Director of the State Council of Higher Education for Virginia (1977–1997) and President of the Kentucky Council on Postsecondary Education (1998–2002).
- Dr. Roger L. Depue, a 20-year veteran of the FBI and the founder, past president and CEO of The Academy Group, Inc., a forensic behavioral sciences services company providing consultation, research, and investigation of aberrant and violent behavioral problems.

- Carroll Ann Ellis, MS, Director of the Fairfax County Police Department's Victim Services Division, a faculty member at the National Victim Academy, and a member of the American Society of Victimology.
- The Honorable Tom Ridge, former Governor of Pennsylvania (1995–2001) and Member of the U.S. House of Representatives (1983–1995) who was also the first U.S. Secretary of Homeland Security (2003–2005).
- Dr. Aradhana A. "Bela" Sood, Professor of Psychiatry and Pediatrics, Chair of Child and Adolescent Psychiatry and Medical Director of the Virginia Treatment Center for Children at VCU Medical Center.
- The Honorable Diane Strickland, former judge of the 23rd Judicial Circuit Court in Roanoke County (1989–2003) and co-chair of the Boyd-Graves Conference on issues surrounding involuntary mental commitment.

These nationally recognized individuals brought expertise in many areas, including law enforcement, security, governmental management, mental health, emergency care, victims' services, the Virginia court system, and higher education.

An assignment of this importance required expert technical assistance and this was provided by TriData, a division of System Planning Corporation. TriData has worked on numerous reports following disasters and tragedies, including a report on the 1999 shooting at Columbine High School. Phil Schaenman and Hollis Stambaugh led the TriData team.

The Panel also needed wise and dedicated legal counsel and that counsel was provided on a pro bono basis by the Washington, D.C., office of the law firm Skadden, Arps, Slate, Meagher & Flom LLP. The Skadden Arps team was led by partners Richard Brusca and Amy Sabrin.

The level of personal commitment by the Panel members, staff and counsel throughout the process was extraordinary. This report is the product of intense work and deliberation and the Commonwealth stands indebted to all who worked on it.

The magnitude of the losses suffered by victims and their families, the Virginia Tech community, and our Commonwealth is immeasurable. We have lost people of great character and intelligence who came to Virginia Tech from around our state, our nation and the world. While we can never know the full extent of the contributions they would have made had their lives not been cut short, we can say with confidence that they had already given much of themselves toward advancing knowledge and helping others.

We must now challenge ourselves to study this report carefully and make changes that will reduce the risk of future violence on our campuses. If we act in that way, we will honor the lives and sacrifices of all who suffered on that terrible day and advance the notion of service that is Virginia Tech's fundamental mission.

ADDITIONS AND CORRECTIONS

(No changes from original report.)

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ACKNOWLEDGEMENTS

The Virginia Tech Review Panel thanks the many persons who contributed to gathering information, provided facilities at which the panel held four public meetings around the state, and helped prepare this report. The administration and staff of Virginia Tech, George Mason University, and the University of Virginia hosted public meetings at which speakers presented background information and family members of the victims addressed the panel. The University of Virginia also provided facilities for the panel to meet in three sessions to discuss confidential material related to this report.

The panel is grateful to more than 200 persons who were interviewed or who participated in discussion groups. They are identified in Appendix B.

Finally, the panel is grateful for staff support and legal advice provided by TriData, a Division of System Planning Corporation, and Skadden, Arps, Slate, Meagher & Flom LLP.

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ADDITIONS AND CORRECTIONS

(No changes from original report.)

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SUMMARY OF KEY FINDINGS

On April 16, 2007, Seung Hui Cho, an angry and disturbed student, shot to death 32 students and faculty of Virginia Tech, wounded 17 more, and then killed himself.

The incident horrified not only Virginians, but people across the United States and throughout the world.

Tim Kaine, Governor of the Commonwealth of Virginia, immediately appointed a panel to review the events leading up to this tragedy; the handling of the incidents by public safety officials, emergency services providers, and the university; and the services subsequently provided to families, survivors, care-givers, and the community.

The Virginia Tech Review Panel reviewed several separate but related issues in assessing events leading to the mass shootings and their aftermath:

- The life and mental health history of Seung Hui Cho, from early childhood until the weeks before April 16.
- Federal and state laws concerning the privacy of health and education records.
- Cho's purchase of guns and related gun control issues.
- The double homicide at West Ambler Johnston (WAJ) residence hall and the mass shootings at Norris Hall, including the responses of Virginia Tech leadership and the actions of law enforcement officers and emergency responders.
- Emergency medical care immediately following the shootings, both onsite at Virginia Tech and in cooperating hospitals.
- The work of the Office of the Chief Medical Examiner of Virginia.
- The services provided for surviving victims of the shootings and others injured, the families and loved ones of those killed and injured, members of the university community, and caregivers.

The panel conducted over 200 interviews and reviewed thousands of pages of records, and reports the following major findings:

1. Cho exhibited signs of mental health problems during his childhood. His middle and high schools responded well to these signs and, with his parents' involvement, provided services to address his issues. He also received private psychiatric treatment and counseling for selective mutism and depression.

   In 1999, after the Columbine shootings, Cho's middle school teachers observed suicidal and homicidal ideations in his writings and recommended psychiatric counseling, which he received. It was at this point that he received medication for a short time. Although Cho's parents were aware that he was troubled at this time, they state they did not specifically know that he thought about homicide shortly after the 1999 Columbine school shootings.

2. During Cho's junior year at Virginia Tech, numerous incidents occurred that were clear warnings of mental instability. Although various individuals and departments within the university knew about each of these incidents, the university did not intervene effectively. No one knew all the information and no one connected all the dots.

3. University officials in the office of Judicial Affairs, Cook Counseling Center, campus police, the Dean of Students, and others explained their failures to communicate with one another or with Cho's parents by noting their belief that such communications are prohibited by the federal laws governing the privacy of health and education records. In reality, federal laws and their state counterparts afford ample leeway to share information in potentially dangerous situations.

4. The Cook Counseling Center and the university's Care Team failed to provide needed support and services to Cho during a period in late 2005 and early 2006. The system failed for lack of resources, incorrect interpretation of privacy laws, and passivity. Records of Cho's minimal treatment at Virginia Tech's Cook Counseling Center are missing.

5. Virginia's mental health laws are flawed and services for mental health users are inadequate. Lack of sufficient resources results in gaps in the mental health system including short term crisis stabilization and comprehensive outpatient services. The involuntary commitment process is challenged by unrealistic time constraints, lack of critical psychiatric data and collateral information, and barriers (perceived or real) to open communications among key professionals.

6. There is widespread confusion about what federal and state privacy laws allow. Also, the federal laws governing records of health care provided in educational settings are not entirely compatible with those governing other health records.

7. Cho purchased two guns in violation of federal law. The fact that in 2005 Cho had been judged to be a danger to himself and ordered to outpatient treatment made him ineligible to purchase a gun under federal law.

8. Virginia is one of only 22 states that report any information about mental health to a federal database used to conduct background checks on would-be gun purchasers. But Virginia law did not clearly require that persons such as Cho—who had been ordered into out-patient treatment but not committed to an institution—be reported to the database. Governor Kaine's executive order to report all persons involuntarily committed for outpatient treatment has temporarily addressed this ambiguity in state law. But a change is needed in the Code of Virginia as well.

9. Some Virginia colleges and universities are uncertain about what they are permitted to do regarding the possession of firearms on campus.

10. On April 16, 2007, the Virginia Tech and Blacksburg police departments responded quickly to the report of shootings at West Ambler Johnston residence hall, as did the Virginia Tech and Blacksburg rescue squads. Their responses were well coordinated.

11. The Virginia Tech police may have erred in prematurely concluding that their initial lead in the double homicide was a good one, or at least in conveying that impression to university officials while continuing their investigation. They did not take sufficient action to deal with what might happen if the initial lead proved erroneous. The police

reported to the university emergency Policy Group that the "person of interest" probably was no longer on campus.

12. The VTPD erred in not requesting that the Policy Group issue a campus-wide notification that two persons had been killed and that all students and staff should be cautious and alert.

13. Senior university administrators, acting as the emergency Policy Group, failed to issue an all-campus notification about the WAJ killings until almost 2 hours had elapsed. University practice may have conflicted with written policies.

14. The presence of large numbers of police at WAJ led to a rapid response to the first 9-1-1 call that shooting had begun at Norris Hall.

15. Cho's motives for the WAJ or Norris Hall shootings are unknown to the police or the panel. Cho's writings and videotaped pronouncements do not explain why he struck when and where he did.

16. The police response at Norris Hall was prompt and effective, as was triage and evacuation of the wounded. Evacuation of others in the building could have been implemented with more care.

17. Emergency medical care immediately following the shootings was provided very effectively and timely both onsite and at the hospitals, although providers from different agencies had some difficulty communicating with one another. Communication of accurate information to hospitals standing by to receive the wounded and injured was somewhat deficient early on. An emergency operations center at Virginia Tech could have improved communications.

18. The Office of the Chief Medical Examiner properly discharged the technical aspects of its responsibility (primarily autopsies and identification of the deceased). Communication with families was poorly handled.

19. State systems for rapidly deploying trained professional staff to help families get information, crisis intervention, and referrals to a wide range of resources did not work.

20. The university established a family assistance center at The Inn at Virginia Tech, but it fell short in helping families and others for two reasons: lack of leadership and lack of coordination among service providers. University volunteers stepped in but were not trained or able to answer many questions and guide families to the resources they needed.

21. In order to advance public safety and meet public needs, Virginia's colleges and universities need to work together as a coordinated system of state-supported institutions.

As reflected in the body of the report, the panel has made more than 70 recommendations directed to colleges, universities, mental health providers, law enforcement officials, emergency service providers, law makers, and other public officials in Virginia and elsewhere.

ADDITIONS AND CORRECTIONS

Missing Records: p. 2, Finding #4, Addition – Cho's records that were missing from the Cook Counseling Center in 2007 subsequently were found in the summer of 2009. They had been inadvertently removed by the then Director of the Counseling Center, Dr. Robert Miller, who said he found them at his home while looking for records in response to the discovery process related to legal proceedings.

Guns on Campus: p. 2, Finding #9, Addition – Virginia Tech had a "no guns" on campus policy in place in 2007.

Conflicting Policy: p. 3, Finding #13, Correction – Virginia Tech had two different emergency notification policies in effect on April 16, 2007. Their actions followed one of the policies but conflicted with the other regarding police authority to send out an alert. The mechanics of the alert system precluded police from sending an alert directly.

Timely Notification of Families of Double Homicide Victims: p. 3, New Finding #22 – Emily Hilscher (one of the victims of the double homicide at West Ambler Johnston) survived for three hours and was transported from the scene to one hospital and later transferred to another. Despite the fact that her identity was known neither Virginia Tech nor law enforcement nor hospital representatives informed her parents that she had been shot and seriously wounded, or where she had been taken for medical treatment, until after her death.

Chapter I.
BACKGROUND AND SCOPE

On April 16, 2007, one student, senior Seung Hui Cho, murdered 32 and injured 17 students and faculty in two related incidents on the campus of Virginia Polytechnic Institute and State University ("Virginia Tech"). Three days later, Virginia Governor Tim Kaine commissioned a panel of experts to conduct an independent, thorough, and objective review of the tragedy and to make recommendations regarding improvements to the Commonwealth's laws, policies, procedures, systems and institutions, as well as those of other governmental entities and private providers. On June 18, 2007, Governor Kaine issued Executive Order 53 reaffirming the establishment of the Virginia Tech Review Panel and clarifying the panel's authority to obtain documents and information necessary for its review. (See Executive Order 53 (2007), Appendix A.)

Each member of the appointed panel had expertise in areas relevant to its work, including Virginia's mental health system, university administration, public safety and security, law enforcement, victim services, emergency medical services, and the justice system. The panel members and their qualifications are specified in the Foreword to this report. The panel was assisted in its research and logistics by the TriData Division of System Planning Corporation (SPC).

In June, the governor appointed the law firm of Skadden, Arps, Slate, Meagher & Flom, LLP, as independent legal counsel to the panel. A team of their lawyers provided their services on a pro bono basis. Their advice helped enormously as they identified the authority needed to obtain key information and guided the panel through many sensitive legal areas related to obtaining and protecting information, public access to the panel and its work, and other issues. Their advice and counsel were invaluable.

The governor requested a report be submitted in August 2007. The panel devoted substantial time and effort from early May to late August to completing its review and preparing the report. All panel members served pro bono. The panel recognizes that some matters may need to be addressed more fully in later research.

SCOPE

The governor's executive order directed the panel to answer the following questions:

1. "Conduct a review of how Seung Hui Cho committed these 32 murders and multiple additional woundings, including without limitation how he obtained his firearms and ammunition, and to learn what can be learned about what caused him to commit these acts of violence.

2. "Conduct a review of Seung Hui Cho's psychological condition and behavioral issues prior to and at the time of the shootings, what behavioral aberrations or potential warning signs were observed by students, faculty and/or staff at Westfield High School and Virginia Tech. This inquiry should include the response taken by Virginia Tech and others to note psychological and behavioral issues, Seung Hui Cho's interaction with the mental health delivery system, including without limitation judicial intervention, access to services, and communication between the mental health services system and Virginia Tech. It should also include a review of educational, medical and judicial records documenting his

condition, the services rendered to him, and his commitment hearing.

3. "Conduct a review of the timeline of events from the time that Seung Hui Cho entered West Ambler Johnston dormitory until his death in Norris Hall. Such review shall include an assessment of the response to the first murders and efforts to stop the Norris Hall murders once they began.

4. "Conduct a review of the response of the Commonwealth, all of its agencies, and relevant local and private providers following the death of Seung Hui Cho for the purpose of providing recommendations for the improvement of the Commonwealth's response in similar emergency situations. Such review shall include an assessment of the emergency medical response provided for the injured and wounded, the conduct of post-mortem examinations and release of remains, on-campus actions following the tragedy, and the services and counseling offered to the victims, the victims' families, and those affected by the incident. In so doing, the panel shall to the extent required by federal or state law: (i) protect the confidentiality of any individual's or family member's personal or health information; and (ii) make public or publish information and findings only in summary or aggregate form without identifying personal or health information related to any individual or family member unless authorization is obtained from an individual or family member that specifically permits the panel to disclose that person's personal or health information.

5. "Conduct other inquiries as may be appropriate in the panel's discretion otherwise consistent with its mission and authority as provided herein.

6. "Based on these inquiries, make recommendations on appropriate measures that can be taken to improve the laws, policies, procedures, systems and institutions of the Commonwealth and the operation of public safety agencies, medical facilities, local agencies, private providers, universities, and mental health services delivery system."

In summary, the panel was tasked to review the events, assess actions taken and not taken, identify lessons learned, and propose alternatives for the future. Its assignment included a review of Cho's history and interaction with the mental health and legal systems and of his gun purchases. The panel was also asked to review the emergency response by all parties (law enforcement officials, university officials, medical responders and hospital care providers, and the Medical Examiner). Finally, the panel reviewed the aftermath—the university's approach to helping families, survivors, students, and staff as they dealt with the mental trauma and the approach to helping the university itself heal and function again.

METHODOLOGY

The panel used a variety of research and investigatory techniques and procedures, with the goal of conducting its review in a manner that was as open and transparent as possible, consistent with protecting individual privacy where appropriate and the confidentiality of certain records where required to do so.

Much of the panel's work was done in parallel by informal subgroups on topics such as mental health and legal issues, emergency medical services, law enforcement, and security. The panel was supplemented by SPC/TriData and Skadden staff with expertise in these areas. Throughout the process, panel members identified documents to be obtained and people to be interviewed. The list of interview subjects continued to grow as the review led to new questions and as people came forth to give information and insights to the panel.

From the beginning, the concept was to structure the review according to the broad timeline pertinent to the incidents: pre-incident (Cho's history and security status of the university); the two shooting incidents and the emergency response to them; and the aftermath. This helped ensure that all issues were covered in a logical, systematic fashion.

Openness –The panel's objective was to conduct the review process as openly as possible while maintaining confidential aspects of the police investigation, medical records, court records, academic records, and information provided in confidence. The panel's work was governed by the Virginia Freedom of Information Act, and the requirements of that act were adhered to strictly.

Requests for Documents and Information – An essential aspect of the review was the cooperation the panel received from many institutions and individuals, including the staff of Virginia Tech, Fairfax County Public School officials and employees, the families of shooting victims, survivors, the Cho family, law enforcement agencies, mental health providers, the Virginia Medical Examiner, and emergency medical responders, as well as numerous public agencies and private individuals who responded to the panel's requests for documents and information.

Notwithstanding some difficulties at the outset, the Executive Order of June 18, 2007, and the work of our outside counsel ultimately allowed the panel to obtain copies of, review, or be briefed on all records germane to its review. In this regard, however, a few matters should be noted. First, as explained more fully in the body of the report, the university's Cook Counseling Center advised the panel that it was missing certain records related to Cho that would be expected to be in the center's files.

Second, due to the sensitive nature of portions of the law enforcement investigatory record and due to law enforcement's concerns about not setting a precedent with regard to the release of raw information from investigation files, the panel received extensive briefings and summaries from law enforcement officials about their investigation rather than reviewing those files directly. These included briefings by campus police, Blacksburg Police, Montgomery County Police, Virginia State Police, FBI, and U.S. Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF). The first two such briefings were conducted in private because they included protected criminal investigation information and some material that was deemed insensitive to air in public. Most of the information received in confidence was subsequently released in public briefings and through the media. Although the panel did not have direct access to criminal investigation files and materials in their entirety, the panel was able to validate the information contained in these briefings from the records it did have access to from other sources and from discussions with many of the same witnesses who spoke to the criminal investigators. The panel believes that it has obtained an accurate picture of the police response and investigation.

Finally, with respect to Cho's firearms purchases, the Virginia State Police, the ATF, and the gun dealers each declined to provide the panel with copies of the applications Cho completed when he bought his weapons or of other records relating to any background check that may have occurred in connection with those purchases. The Virginia State Police, however, did describe the contents of Cho's gun purchase applications to members of the panel and its staff.

Virginia Tech Cooperation – An essential aspect of the review was the cooperation of the Virginia Tech administration and faculty. Despite their having to deal with extraordinary problems, pressures, and demands, the university provided the panel with the records and information requested, except for a few that were missing. Some information was delayed until various privacy issues were resolved, but ultimately all records that were requested and still existed were provided. University President Charles Steger appointed a liaison to the panel, Lenwood McCoy, a retired senior university

official. Requests for meetings and information went to him. He helped identify the right people to provide the requested information or obtained the information himself. The panel sometimes requested to speak to specific individuals, and all were made available. Many of the exchanges were monitored by the university's attorney, who is a special assistant state attorney general. Overall, the university was extremely cooperative with the panel, despite knowing that the panel's duty was to turn a critical eye on everything it did.

Interviews – Many interviews were conducted by panel members and staff during the course of this review—over 200. A list of persons interviewed is included in Appendix B. A few interviewees wanted to remain anonymous and are not included. Panel members and staff held numerous private meetings with family members of victims and with survivors and their family members.

One group of interviews was to obtain first-hand information about the incidents from victims and responders. This included surviving students and faculty, police, emergency medical personnel and hospital emergency care providers, and coordinators. The police used hundreds of personnel from many law enforcement agencies for their investigation, and the panel did not have nor need the resources to duplicate that effort. Rather, the panel obtained the benefit of much of the investigative information from the law enforcement agencies. Interviews were conducted with survivors, witnesses, and responders to validate the information received and to expand upon it.

To further evaluate the actions taken by law enforcement, the university, and emergency medical services against state and national standards and norms, panel members and staff also conducted interviews with leaders in these fields outside the Virginia Tech community, from elsewhere in Virginia and from other states. The panel also solicited their expert opinions on how things might have been done better, and what things were done well that should be emulated.

Interviews were conducted to understand Cho's history, including his medical and mental health treatment during his early school and university years, and his interactions with the mental health and legal systems. This included interviews with the Cho family, Cho's high school staff and faculty, staff and faculty at the university, many of those involved with the mental health treatment of Cho within and outside the university (including the Cook Counseling Center and his high school counseling), and members of the legal community who had contact with him. The assistance of attorney Wade Smith of Raleigh, NC, was important in dealing with the Cho family. He helped obtain signed releases from the family and arranged an interview with them. Various experts in mental health were consulted on the problems with the mental health and legal system within Virginia that dealt with Cho. They also provided insight on ways to identify and help such individuals in other systems.

In evaluating the aftermath—the attempt to mitigate the damage done to so many families, members of the university community, and the university itself—many interviews were conducted with family members of the victims, survivors and their families, people interacting with the families and survivors, and others. The family members were extended opportunities to speak to the panel in public or private sessions, as were the injured and some other survivors. For these groups, everyone who requested an interview was given one. Not all wanted interviews. Some wanted group interviews. Some were ready to speak earlier or later than others. To the best of the panel's knowledge, and certainly its intent, all were accommodated. The panel learned a great deal about the incident and also confronted directly the indescribable grief and loss experienced by so many. From families and survivors, the panel learned about the positive aspects of the services provided after April 16 and also about the many perceived problems with those services. The panel also considered the many issues that the family members asked to be included in the investigation. This input

was invaluable and substantially improved this report.

Most of the formal interviews were conducted by one or two panel members, often with one or two TriData staff present. Some were conducted solely by staff. Generally, they were conducted in private. No recordings or written transcripts were made. All those interviewed were told that the information they provided might be used in the report but if they wished, they would not be quoted or identified. These steps were taken to encourage candor and to protect remarks that were provided with the caveat that they not be attributed to the speaker. The panel believes it was able to obtain more candid and useful information using this approach. Panel members and staff had many informal conversations with colleagues in their fields to obtain additional insights, generally not in formal settings.

Literature Research – Especially toward the beginning of the review but continuing throughout, much research was undertaken on various topics through the Internet and through information sources suggested by panel members and by individuals with whom the panel came into contact. Many useful references were submitted to the panel by the general public and experts.

Public Meetings – A key part of the panel's review process was a series of four public meetings held in different parts of the Commonwealth to accommodate those who wished to contribute information. The first meeting was held in Richmond at the state capitol complex, followed by meetings at Virginia Tech, George Mason University, and the University of Virginia. This facilitated input from the public and officials of various universities on issues they all cared deeply about. Several other universities offered facilities besides those chosen, including some out of state. Each university site was fully supported by their leadership, public relations department, event planning staff, and campus police. The Virginia State Police provided added protection at the meetings. (The agendas of the public meetings are given in Appendix C.)

In addition to the primary speakers, every public meeting included time for public comment. In some cases the people testifying were representatives of lobbying groups, organizations, and associations, but the panel also heard from victims, family members of victims, independent experts, and concerned citizens. There was even one instance of a cameraman who put his camera down and testified. Generally, the public presenters were expected to restrict themselves to a few minutes, and most did not abuse the opportunity. At one meeting, more people wanted to speak than time available, even though the meeting was extended an hour. Those not able to present information still had the opportunity to submit it to the panel through letters, e-mails, or phone calls, and many did.

Web Site and Post Office Box – Shortly after the panel was formed, its staff created a web site that was used both to inform the public and to receive input from the public. It proved to be very valuable. There was a minimum of spam or inappropriate inputs. The web site was used to post announcements of public meetings and to post presentations made or visual aids used at meetings. More than 400,000 "hits" were recorded, with 26,000 unique visitors. The web site also was advertised as a vehicle for anyone to post information or opinions. As of August 9, 2007, more than 2,000 comments were posted from experts in various fields as well as the general public, victims, families of victims, and others as follows:

Parents (self-identified)	251
General public	1,547
Educators	91
EMS	8
Students	48
Law enforcement officers	18
Family members of victims	12
Health professionals	102
Virginia Tech staff	2
Total	**2,079**

Most persons who submitted information to the web site appeared sincere about making a

contribution. Some lobbying groups on issues such as gun control, carrying guns on campus, and the influence of video games on young people clearly urged their members to post comments.

A post office box also was opened for the public to address comments directly to the panel. The number of letters received was much smaller than the number of e-mails but generally with a high percentage of relevancy, especially from experts, families, and victims.

Telephone Calls and E-Mails – Some information was received directly by panel members or staff through phone calls or e-mails. Much of this information was received by one panel member or staff member and was shared with others when thought important.

Panel Interactions – The members of the Virginia Tech Review Panel engaged on a personal level, participating in the majority of interviews conducted and exchanging many e-mails and phone calls among themselves and with the panel staff. The panel was impeded by the FOIA rules that did not allow more than two members to meet together or speak by phone without it being considered a public meeting.

FINDINGS AND RECOMMENDATIONS

The panel's findings and recommendations are provided throughout the report. Recommendations regarding the methodology used by the panel are presented in Appendix D; they were put in an appendix to avoid having the procedural issues distract the reader from the heart of the main issues.

The findings and related recommendations in this report are of two kinds. The first comes from reviewing actions taken in a time of crisis: what was done very well, and what could have been done better. Almost any crisis actions can be improved, even if they were exemplary.

The second type of finding identifies major administrative or procedural failings leading up to the events, such as failing to "connect the dots" of Cho's highly bizarre behavior; the missing records at Cook Counseling Center; insensitivity to survivors waiting to learn the fates of their children, siblings, or spouses; and fundraising that appeared opportunistic.

To help in understanding the events, the report begins in Chapter II with a description of the setting of the Virginia Tech campus and its preparedness for a disaster. In Chapter III, a detailed timeline serves as a reference throughout the report—the succinct story of what happened, starting with Cho's background, his treatment, and then proceeding to the events of April 16 and its aftermath. The events are elaborated in subsequent chapters.

ADDITIONS AND CORRECTIONS

Time for Study: p. 5, Addition – The Report noted that the Governor wanted the Report completed by August 2007. A key motivation for this deadline was to get recommendations for campus security improvements disseminated before the start of the school year in Virginia. Also, the deadline was thought necessary to allow time for developing a legislative agenda (suggested changes to laws and policies) needed to implement some of the Report's recommendations in time for Virginia's annual legislative session in January. Further, the Governor wanted to get information out to the families of victims and to the general public as soon as possible.

Access to Records: p. 7, Clarification – The Report said that…"ultimately all records that were requested [from Virginia Tech] and still existed were provided." At the time, Cho's file at the Cook Counseling Center was missing. An extensive search by Virginia Tech, including contact with the previous CCC director, Dr. Miller, did not turn up the file, and no one knew if it still existed. The file was found two years later by Dr. Miller in his home in response to a discovery request by attorneys involved in a lawsuit.

Cooperativeness of University: pp. 7-8, Clarification – Some victims' families questioned whether Virginia Tech should be characterized as "extremely cooperative" with the Review Panel, and whether having a point of contact to obtain information and arrange interviews was a barrier imposed by Virginia Tech. In fact, it was the Review Panel staff that requested a point of contact to facilitate such things as finding and scheduling Virginia Tech faculty and staff for interviews. Reporters, law enforcement officials, and others were pressing for interviews with many of the same Virginia Tech employees that the Review Panel wanted to interview. Having a point of contact streamlined and prioritized the Review Panel's access.

The person appointed by Virginia Tech to be the contact was highly cooperative and greatly facilitated obtaining information. Not surprisingly there were some Virginia Tech faculty and staff who were guarded in discussions with the Review Panel possibly as a result of being interviewed with other Virginia Tech officials present.

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Chapter II.
UNIVERSITY SETTING AND SECURITY

Before describing the details of the events, it is necessary to understand the setting in which they took place, including the security situation at Virginia Tech at the time of the shootings. This chapter focuses on the physical security of the campus and its system for alerting the university community in an emergency. It also gives a brief background on the campus police department and the university's Emergency Response Plan. The prevention aspect of security—including the identification of people who pose safety threats—is discussed in Chapter IV.

UNIVERSITY SETTING

Virginia Tech occupies a beautiful, sprawling campus near the Blue Ridge Mountains in southwest Virginia. It is a state school known for its engineering and science programs but with a wide range of other academic fields in the liberal arts.

The main campus has 131 major buildings spread over 2,600 acres. The campus is not enclosed; anyone can walk or drive onto it. There are no guarded roads or gateways. Cars can enter on any of 16 road entrances, many of which are not in line of sight of each other. Pedestrians can use sidewalks or simply walk across grassy areas to get onto the campus. Figure 1 shows aerial views of the campus. There is a significant amount of ongoing construction of new buildings and renovation of existing buildings, with associated noise.

On April 16, the campus population was about 34,500, as follows:

26,370	students (9,000 live in dorms)
7,133	university employees (not counting student employees)
1,000	visitors, contractors, transit workers, etc.
34,503	**Total**

CAMPUS POLICE AND OTHER LOCAL LAW ENFORCEMENT

A key element in the security of Virginia Tech is its police department. It is considered among the leading campus police departments in the state. While many campuses employ security guards, the Virginia Tech Police Department (VTPD) is an accredited police force. Its officers are trained as a full-fledged police department with an emergency response team (ERT), which is like a SWAT team.

The police chief reports to a university vice president.

On April 16, the VTPD strength was 35 officers. It had 41 positions authorized but 6 were vacant. The day shift, which comes on duty at 7 a.m., has 5 officers. Additionally, 9 officers work office hours, 8 a.m. to 5 p.m., including the chief, for a total of 14 on a typical weekday morning. On April 16, approximately 34 of the officers came to work at some point during the day.

The campus police could not handle a major event by themselves with these numbers, and so they have entered into a mutual aid agreement with the Blacksburg Police Department (BPD) for immediate response and assistance. They frequently train together, and had trained for an active shooter situation in a campus building before the incident. As will be seen, this preparation was critical.

The VT campus police also have excellent working relationships with the regional offices of the state police, FBI, and ATF. The high level of cooperation was confirmed by each of the federal, state, and local law enforcement agencies that were involved in the events on April 16, and by the rapidity of coordination of their response to the incident and the investigation that followed. Training together, working cases together, and

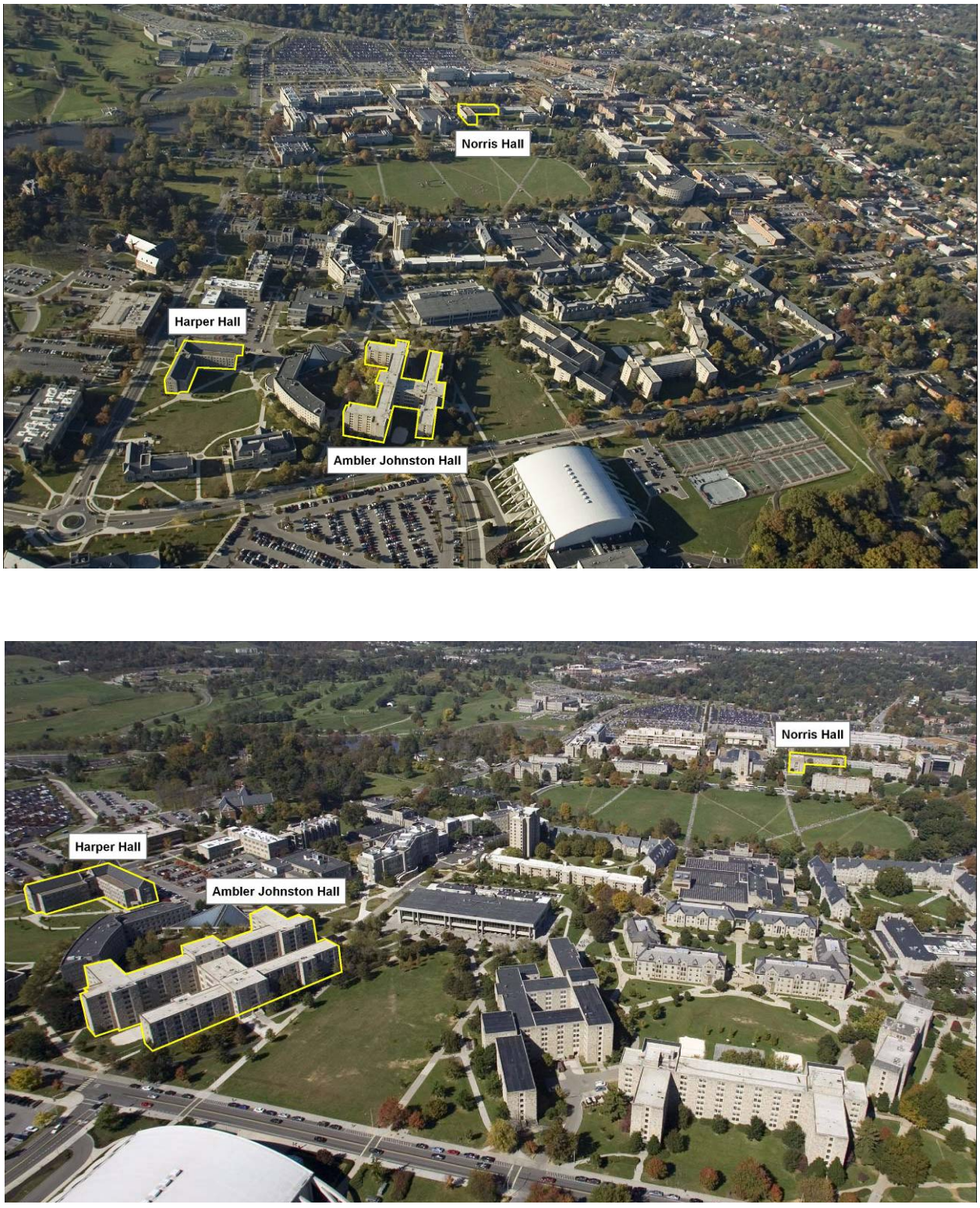

Figure 1. Aerial Views of Virginia Tech Campus

knowing each other on a first-name basis can be critical when an emergency occurs and a highly coordinated effort is needed.

The purpose of the Virginia Tech campus police is stated in the university's Emergency Response Plan as follows: "The primary purpose of the VTPD is to support the academics through maintenance of a peaceful and orderly community and through provision of needed general and emergency services." Although some do not consider police department mission statements of much importance versus how they actually operate, the mission statement may affect their role by indicating priorities. For example, it may influence a decision as to whether the university puts minimizing disruption to the educational process first and acting on the side of precaution second. There are many crimes and false alarms such as bomb threats on campus, and it is often difficult to make the decision on taking precautions that are disruptive. The police mission statement also may affect availability of student information. Explicitly including the police under the umbrella of university officials may allow them to access student records under Family Educational Rights and Privacy Act (FERPA) regulations.

Several leaders of the campus police chiefs of Virginia commented that they do not always have adequate input into security planning and threat assessment or the authority to access important information on students.

BUILDING SECURITY

The residence halls on campus require placing a student or staff keycard in an electronic card reader in order to enter between 10:00 p.m. and 10:00 a.m. A student access card is valid only for his or her own dormitory and for the mailbox area of another dormitory if one's assigned mailbox is there.

Many other school buildings are considered public spaces and are open 24 hours a day. The university encourages students to use the facilities for class work, informal meetings, and officially sanctioned clubs and groups.

Most classrooms, such as those in Norris Hall, have no locks. Staff offices generally do have locks, including those in Norris Hall.

There are no guards at campus buildings or cameras at the entrances or in hallways of any buildings. Anyone can enter most buildings. It is an open university.

Some buildings have loudspeaker systems intended primarily for use of the fire department in an emergency. They were not envisioned for use by police. They can only be used by someone standing at a panel in each building and cannot be accessed for a campus-wide broadcast from a central location.

This level of security is quite typical of many campuses across the nation in rural areas with low crime rates. Some universities are partially or completely fenced, with guards at exterior entrances; usually these are in urban areas. Some universities have guards at the entrance to each building and screen anyone coming in without student or staff identification, again usually on urban campuses. Some universities have locks on classroom doors, but they typically operate by key from the hallway. They are intended to keep students and strangers out when they are not in use and often cannot be locked from the inside.

A few universities (e.g., Hofstra University in Nassau County, NY) now have the ability to lock the exterior doors of some or all buildings at the push of a button in a central security office. Most require manual operation of locks. Virginia Tech would have to call people in scores of buildings or send someone to the buildings to lock their outside doors (except for dormitories between 10 p.m. and 10 a.m. when they are locked automatically).

Many levels of campus security existed at colleges and universities across Virginia and the nation on April 16. A basic mission of institutions of higher education is to provide a peaceful, open campus setting that encourages freedom of movement and expression. Different institutions provide more or less security, often based on their locations (urban, suburban, or rural), size and complexity (from research universities to small private colleges), and resources. April 16 has become the 9/11 for colleges and universities. Most have reviewed their security plans since then. The installation of security systems already planned or in progress has accelerated, including those at Virginia Tech.

Although the 2004 General Assembly directed the Virginia State Crime Commission to study campus safety at Virginia's institutions of higher education (HJR 122), the report issued December 31, 2005, did not reflect the need for urgent corrective actions. So far as the panel is aware, there was no outcry from parents, students, or faculty for improving VT campus security prior to April 16. Most people liked the relaxed and open atmosphere at Virginia Tech. There had been concern the previous August about an escaped convict and killer named William Morva whose escape in the VT vicinity unnerved many people. Also, some campus assaults led some students to want to arm themselves. However, if the April 16 incident had not occurred, it is doubtful that security issues would be on the minds of parents and students more than at other universities, where the most serious crimes tend to be rapes, assaults, and dangerous activity related to alcohol or drug abuse by students. These issues were addressed by the State Crime Commission Report and were given an average level of attention at Virginia Tech.

CAMPUS ALERTING SYSTEMS

Virginia Tech was in the process of upgrading its campus-wide alerting system in spring 2007.

Existing System – Virginia Tech had the capability on April 16 to send messages to the student body, faculty, and other staff via a broadcast e-mail system. The associate vice president for University Relations had the authority and capability to send a message from anywhere that was connected to the web. Almost every student and faculty member on campus has a computer and e-mail address (estimated at 96 percent by the university). Most but not all student computers are portable. Many are carried to classes. However, an e-mail message sent by the university may not get read by every user within minutes or even hours. The e-mail system had 36,000 registered e-mail addresses. Distribution of an emergency message occurred at a rate of about 10,000 per minute.

The university also has a web site that it uses to post emergency warnings, mostly for weather events. The system has high-volume capacity. (As events unfolded on April 16, the VT web site was receiving 148,000 visits per hour.) An emergency message can be put in a box on the web site that anyone reaching the site would see no matter what they were looking for.

The university also has contacts with every local radio and TV station. The Virginia Tech associate vice president for University Relations has a code by which he can send emergency messages to the stations that could be played immediately. This process could take 20 minutes or so because each station has its own code to validate the sender. The validation codes are necessary because students or members of the public could send spoof messages to the media as a prank. The public media are used for the occasional weather emergencies, and the campus community is trained to tune in to get further information.

An estimated 96 percent of students at Virginia Tech carry cell phones according to the university. Most bring them to classes or wherever else they go. A text message to cell phones probably will reach more students faster than an e-mail message because the devices are more portable and can be rung. But some are forgotten, turned

off, or intentionally not carried. The university was still in the process of installing a text messaging system on April 16 and had no way to send a message to all cell phones.

Personal digital assistants (or PDAs) such as Blackberries are used by fewer students and faculty than cell phones because they are more expensive and are not as capable as computers. They have the capacity to receive e-mails and would be treated either as a computer or as a phone or both, depending on how it is registered.

The university also has a broadcast phone-mail system that allows it to send a phone message to all phone numbers registered with its messaging system. VT used this system to send messages to all faculty offices and some students on April 16. Students and faculty must voluntarily register their phones with this system if they want to be notified. It takes time to reach all the phones; 11 separate actions are required to send a broadcast message to all registered numbers, said the associate vice president for University Relations. It is not a useful approach when time is critical.

A university switchboard with up to four operators is working during normal business hours. It can handle hundreds of calls per hour.

To augment the range of messaging systems it had available, the university was in the process of installing six outdoor loudspeakers to make emergency announcements. Some are mounted on buildings and others on poles, as shown in Figure 2. They can be used for either a voice message or an audible alarm (such as a siren). Four had been installed and were used on April 16, but they did not play a significant role in this incident. (The announcement was made after the 9:05 a.m. class period in which the mass shooting had already started.)

As part of its emergency planning, the university has another system in place as a last-ditch resort—using resident advisors in dorms and floor wardens in some older classroom and office

Figure 2. One of the Six Sirens Being Installed on Virginia Tech Campus

buildings to personally spread a warning. In Norris Hall, for example, the chairman of the Engineering Mechanics Department, whose office was on the second floor, said he had been issued a bullhorn to make announcements and was instructed to rap on classroom and office doors to alert people if there was an emergency and other notification systems failed, if a personal approach was needed to convey safety information, or if an evacuation or sheltering in place was required.

New Unified Campus Alerting System – In spring 2007, Virginia Tech was in the process of installing a unified, multimedia messaging system to be completed before the next semester. It would allow university officials to send an emergency message that would flow in parallel to computers, cell phones, PDAs, and telephones. The message could be sent by anyone who is registered in the system as having authority to send one, using a code word for validation. The president of the university or associate vice president of University Relations

can be anywhere and send a message to everyone—all that is needed is an Internet connection.

Students must be registered with the new system to receive messages. A student can provide a mobile phone number, e-mail address(es), or instant messaging system to be contacted in an emergency. Parents' numbers can be included. All students and staff are encouraged but not required to register with the new system. Each user can set the priority order in which their devices are to be called. The message will cascade through the hierarchy set by each user until it gets answered.[1] This system has the enormous advantage of transmitting a message to the entire university community in less than a minute.

For the Virginia Tech community of about 35,000 users, the system will cost $33,000 a year to operate and no out-of-pocket expense to start. However, it takes considerable staff time to select a system and then oversee its startup. The operating cost is a function of the bandwidth used and the frequency of messages. The more people and devices on the system and the more messages sent per year, the higher the cost. Initially, Virginia Tech is planning to use the system only for emergency messages. Other schools have started using such systems for more routine purposes such as sending information about special events on campus and administrative information, at an extra charge. Virginia Tech was willing to share the criteria it used in its selection of a messaging system (Appendix E). Several competing commercial options have excellent capabilities. Some are only suitable for small schools. Universities and colleges need to balance their needs and the system capability versus costs.

Message Content and Authorization – A critical part of security is not only having the technical communication capability of reaching students and staff quickly, but also planning what to say and how quickly to say it. Pursuant to its Emergency Response Plan in effect on April 16, the Virginia Tech Policy Group and the police chief could authorize sending an emergency message to all students and staff. Typically, the police chief would make a decision about the timing and content of a message after consultation with the Policy Group, which is comprised of the president and several other vice presidents and senior officials. This process of having the Policy Group decide on the message was used during the April 16 incidents. However, while the Virginia Tech campus police had the authority to send a message, they did not have the technical means to do so. Only two people, the associate vice president for University Relations and the director of News and Information, had the codes to send a message. The police could not access the alerting system to send a message. The police had to contact the university leadership on the need and proposed content of a message. As a matter of course, the police would usually be consulted if not directly involved in the decision regarding the sending of an alert for an emergency.

There are no preset messages for different types of emergencies, as some public agencies have in order to speed crafting of an emergency message. All VT messages are developed for the particular incident.

The timing and content of the messages sent by the university are one of the major controversies concerning the events of April 16. (Chapter VIII addresses the double homicide at West Ambler Johnston residence hall and the messaging decisions that followed).

EMERGENCY RESPONSE PLAN

The university's Emergency Response Plan deals with preparedness and response to a variety of emergencies, but nothing specific to shootings. The version in effect on April 16 was about 2 years old. Emergencies such as weather

[1] A system being developed sends a message to anyone within range of a tower or set of towers. It does not matter who you are or whether you have "registered"; if you have a cell phone and are in range, you get the message.

problems, fires, and terrorism were in the fore of VT emergency planning pre-April 16.[2]

The plan addresses different levels of emergencies, designated as levels 0, I, II, and III. The Norris Hall event was level III, the highest, based on the number of lives lost, the physical and psychological damage suffered by the injured, and the psychological impact on a very large number of people.

The plan calls for an official to be designated as an emergency response coordinator (ERC) to direct a response. It also calls for the establishment of an emergency operations center (EOC). Satellite operations centers may be established to assist the ERC. As will be discussed in describing the response to the events, there were multiple coordinators and multiple operations centers but not a central EOC on April 16.

Two key decision groups are identified in the Emergency Response Plan: the Policy Group and the Emergency Response Resources Group. The Policy Group is comprised of nine vice presidents and support staff, chaired by the university president. The Policy Group deals with procedures to support emergency operations and to determine recovery priorities. In the events of April 16, it also decided on the messages sent and the immediate actions taken by the university after the first incident as well as the second mass shooting. The Policy Group sits above the emergency coordinator for an incident. It does not include a member of the campus police, but the campus police are usually asked to have a representative at its meetings.

The second key group, the Emergency Response Resources Group (ERRG), includes a vice president designated to be in charge of an incident, police officials, and others depending on the nature of the event. It is to ensure that the resources needed to support the Policy Group and needs of the emergency are available. The ERRG is organized and directed by the emergency response coordinator. The ERRG is supposed to meet at the EOC. Decisions made by these groups and their members on April 16 are addressed in the remainder of the report, as the event is described.

The VT Emergency Response Plan does not deal with prevention of events, such as establishing a threat assessment team to identify classes of threats and to assess the risk of specific problems and specific individuals. There are threat assessment models used elsewhere that have proven successful. For example, at two college campuses in Virginia, the chief operating officer receives daily reports of all incidents to which law enforcement responded the previous day, including violation of the student conduct code up to criminal activity. This information is then routinely shared with appropriate offices which are responsible for safety and health on campus.

KEY FINDINGS

The Emergency Response Plan of Virginia Tech was deficient in several respects. It did not include provisions for a shooting scenario and did not place police high enough in the emergency decision-making hierarchy. It also did not include a threat assessment team. And the plan was out of date on April 16; for example, it had the wrong name for the police chief and some other officials.

The protocol for sending an emergency message in use on April 16 was cumbersome, untimely, and problematic when a decision was needed as soon as possible. The police did not have the capability to send an emergency alert message on their own. The police had to await the deliberations of the Policy Group, of which they are not a member, even when minutes count. The Policy Group had to be convened to decide whether to send a message to the university community and to structure its content.

The training of staff and students for emergencies situations at Virginia Tech did not include shooting incidents. A messaging system works more effectively if resident advisors in dormitories, all faculty, and all other staff from janitors

[2] Appendix F has an example of the "active shooter" part of the University of Virginia's plan, and something similar should be included in the Virginia Tech plan.

to the president have instruction and training for coping with emergencies of all types.

It would have been extremely difficult to "lock down" Virginia Tech. The size of the police force and absence of a guard force, the lack of electronic controls on doors of most buildings other than residence halls, and the many unguarded roadways pose special problems for a large rural or suburban university. The police and security officials consulted in this review did not think the concept of a lockdown, as envisioned for elementary or high schools, was feasible for an institution such as Virginia Tech.

It is critical to alert the entire campus population when there is an imminent danger. There are information technologies available to rapidly send messages to a variety of personal communication devices. Many colleges and universities, including Virginia Tech, are installing such campus-wide alerting systems. Any purchased system must be thoroughly tested to ensure it operates as specified in the purchase contract. Some universities already have had problems with systems purchased since April 16.

An adjunct to a sophisticated communications alert system is a siren or other audible warning device. It can give a quick warning that something is afoot. One can hear such alarms regardless of whether electronics are carried, whether the electronics are turned off, or whether electric power (other than for the siren, which can be self-powered) is available. Upon sounding, every individual is to immediately turn on some communication device or call to receive further instructions. Virginia Tech has installed a system of six audible alerting devices of which four were in place on April 16. Many other colleges and universities have done something similar.

No security cameras were in the dorms or anywhere else on campus on April 16. The outcome might have been different had the perpetrator of the initial homicides been rapidly identified. Cameras may be placed just at entrances to buildings or also in hallways. However, the more cameras, the more intrusion on university life.

Virginia Tech did not have classroom door locks operable from the inside of the room. Whether to add such locks is controversial. They can block entry of an intruder and compartmentalize an attack. Locks can be simple manually operated devices or part of more sophisticated systems that use electromechanical locks operated from a central security point in a building or even university-wide. The locks must be easily opened from the inside to allow escape from a fire or other emergency when that is the safer course of action. While adding locks to classrooms may seem an obvious safety feature, some voiced concern that locks could facilitate rapes or assaults in classrooms and increase university liability. (An attacker could drag someone inside a room at night and lock the door, blocking assistance.) On the other hand, a locked room can be a place of refuge when one is pursued. On balance, the panel generally thought having locks on classroom doors was a good idea.

Shootings at universities are rare events, an average of about 16 a year across 4,000 institutions. Bombings are rarer but still possible. Arson is more common and drunk driving incidents more frequent yet. There are both simple and sophisticated improvements to consider for improving security (besides upgrading the alerting system). A risk analysis needs to be performed and decisions made as to what risks to protect against.

There have been several excellent reviews of campus security by states and individual campuses (for example, the states of Florida and Louisiana, the University of California, and the University of Maryland). The Commonwealth of Virginia held a conference on campus security on August 13, 2007.

The VTPD and BPD were well-trained and had conducted practical exercises together. They had undergone active shooter training to prepare for the possibility of a multiple victim shooter.

The entire police patrol force must be trained in the active shooter protocol, because any officer may be called upon to respond.

It was the strong opinion of groups of Virginia college and university presidents with whom the panel met that the state should not impose required levels of security on all institutions, but rather let the institutions choose what they think is appropriate. Parents and students can and do consider security a factor in making a choice of where to go to school.

Finally, the panel found that the VTPD statement of purpose in the Emergency Response Plan does not reflect that law enforcement is the primary purpose of the police department.

RECOMMENDATIONS

EMERGENCY PLANNING

II-1 Universities should do a risk analysis (threat assessment) and then choose a level of security appropriate for their campus. How far to go in safeguarding campuses, and from which threats, need to be considered by each institution. Security requirements vary across universities, and each must do its own threat assessment to determine what security measures are appropriate.

II-2 Virginia Tech should update and enhance its Emergency Response Plan and bring it into compliance with federal and state guidelines.

II-3 Virginia Tech and other institutions of higher learning should have a threat assessment team that includes representatives from law enforcement, human resources, student and academic affairs, legal counsel, and mental health functions. The team should be empowered to take actions such as additional investigation, gathering background information, identification of additional dangerous warning signs, establishing a threat potential risk level (1 to 10) for a case, preparing a case for hearings (for instance, commitment hearings), and disseminating warning information.

II-4 Students, faculty, and staff should be trained annually about responding to various emergencies and about the notification systems that will be used. An annual reminder provided as part of registration should be considered.

II-5 Universities and colleges must comply with the Clery Act, which requires timely public warnings of imminent danger. "Timely" should be defined clearly in the federal law.

CAMPUS ALERTING

II-6 Campus emergency communications systems must have multiple means of sharing information.

II-7 In an emergency, immediate messages must be sent to the campus community that provide clear information on the nature of the emergency and actions to be taken The initial messages should be followed by update messages as more information becomes known.

II-8 Campus police as well as administration officials should have the authority and capability to send an emergency message. Schools without a police department or senior security official must designate someone able to make a quick decision without convening a committee.

POLICE ROLE AND TRAINING

II-9 The head of campus police should be a member of a threat assessment team as well as the emergency response team for the university. In some cases where there is a security department but not a police department, the security head may be appropriate.

II-10 Campus police must report directly to the senior operations officer responsible for emergency decision making. They should be part of the policy team deciding on emergency planning.

II-11 Campus police must train for active shooters (as did the Virginia Tech Police Department). Experience has shown that waiting for a SWAT team often takes too long. The

best chance to save lives is often an immediate assault by first responders.

II-12 The mission statement of campus police should give primacy to their law enforcement and crime prevention role. They also must to be designated as having a function in education so as to be able to review records of students brought to the attention of the university as potential threats. The lack of emphasis on safety as the first responsibility of the police department may create the wrong mindset, with the police yielding to academic considerations when it comes time to make decisions on, say, whether to send out an alert to the students that may disrupt classes. On the other hand, it is useful to identify the police as being involved in the education role in order for them to gain access to records under educational privacy act provisions.

Specific findings and recommendations on police actions taken on April 16 are addressed in the later chapters.

ADDITIONS AND CORRECTIONS

Multijurisdictional Police Training: p. 8, Correction – Campus and Blacksburg police had trained together for an active shooter incident as was noted in the Report, but the training was conducted in an empty school building off campus, not on campus.

Mailbox Access and Targeting of Initial Victim: p. 11, Clarification – Some students were assigned mailboxes located in a different dorm from their own. They could access their mailbox after 7:30 a.m. Cho was one of these students. He lived in Harper Hall but his mailbox was in West Ambler Johnston where he committed the first two murders. He had access and reason to be in the mailbox area of WAJ, which may help explain why he chose it. It also was a short walk from his dorm. His motivation for the initial killings still has not been determined. He had no known relationship with Emily Hilscher, nor with her roommate. It is not known and may never be known whether he had targeted Ms. Hilscher beforehand or just happened upon her that fateful morning.

Reason for Closely Held Alert Code: p. 14, Addition – Access codes were required in order to send messages on the campus alerting system and to distribute information to the local media stations at least in part because students had previously sent prank messages about non-existent emergencies. Virginia Tech wanted the alerting system to prevent unauthorized alerts and to validate the emergency messages they broadcast.

Joint Homicide Investigation: p. 18, Addition – While the Virginia Tech and Blacksburg Police Departments had trained and worked well together, including practice for an active shooter, the VTPD had not investigated a homicide since 1984. Its chief and detectives did not have experience as primary investigators for a homicide. Blacksburg investigators had homicide experience, as did the State Police, and VTPD requested immediate assistance from them in the investigation of the shooting.

OTHER COMMENTS

1. **Frequency of Campus Shootings:** Commenter wanted text on page 18 to read that shootings are becoming more frequent, rather than rare, events.

   Response: There was no data provided which showed an increasing trend in frequency over recent years compared to earlier years. The data provided did not focus on universities.

2. **On-Duty Psychiatrist at CCC:** Commenter claimed that there was no psychiatrist on duty at the CCC after Dr. Miller's departure until the arrival of Dr. Flynn.

   Response: There were several psychiatrists on duty during this time period. Dr. Miller was reassigned in January/February 2006. From January through April 2006, Dr. Gary Rooker, a Virginia Tech employee, was the psychiatrist available to assist students. Dr. Brian Bladykus was hired in June of 2006 and worked through February of 2007. Dr. Joseph Frieben was hired half-time August 10, 2006 and full-time on July 1, 2007. Thus, there was a psychiatrist available except for a one-month period in May 2006. When Dr. Flynn started in September 2006, both Dr. Bladykus and Dr. Frieben were at the CCC. Also, throughout this period, Vicki Arbuckle, a psychiatric nurse practitioner, was on staff.

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Chapter III.
REVISED TIMELINE OF EVENTS

The modifications to this chapter resulted primarily from additional information identified and made available since the original Report was published.

In constructing both the original and the revised timelines, care was taken to confirm the dates and times through multiple sources where possible. However, even with the newly available information, some of the times provided are approximate, because not every message, phone call and event was time-stamped. In a few cases where no documentation existed it was necessary to rely on individuals' best recollections of times. Many of the interviews for the original timeline were conducted in the weeks immediately after the shootings. Some individuals reported dates and times as they knew them to be true at that time; however, in a few cases they were misinformed. The revised timeline corrects those errors and adds more details.

The original wording of the timeline generally was preserved except where new information required a change or addition.

The following timeline provides highlights of the events leading up to the tragedy on April 16,2007 the actions taken on April 16, and some subsequent actions. The time scale switches from years to months to days and even to minutes as appropriate. The timeline is an overview and composite of major events, with additional facts and details discussed in the respective chapters. Therefore, the timeline does not include all the details covered later in the chapters, but, rather, is intended to serve as a framework for the reader. The timeline and the Report begin with Seung Hui Cho's childhood and end with Governor Kaine's declaration of a day of mourning, April 20, 2007.

The information here was drawn from numerous interviews, written sources, and briefings. The Cho family and Seung Hui Cho's school administrators, counselors, teachers, and medical and school records are the prime sources for his history prior to attending Virginia Tech.

Information obtained about his Virginia Tech years before the shootings came from interviews with faculty, counselors, administrators, police, courts, psychological evaluators, suitemates, and others. The panel also had access to many Virginia Tech, medical, and court records and to e-mails and other written materials involving Cho.

The timeline for the events of April 16 relied primarily on Virginia Tech Police Department (VTPD) and Virginia State Police (VSP) reports and interviews, supplemented by interviews with survivors, Virginia Tech officials, emergency medical responders, hospitals, state officials and others.

The information on the aftermath drew on medical examiner records, interviews with families and other sources.

Each aspect of the timeline is discussed further in the following chapters, with an evaluation as well as narration of events.

PRE-INCIDENTS: CHO'S HISTORY

1986–2000

1984 Seung Hui Cho is born to a family living in a small two-room apartment in Seoul, South Korea. He is an inordinately shy, quiet child, but no problem to his family. He has serious health problems from 9 months to 3 years old, is frail, and after unpleasant medical procedures does not want to be touched.

1992 Cho's family emigrates to Maryland when he is 8 years old.

1993 The Cho family moves to Fairfax County, Virginia, when he is 9 years old. They work long hours in a dry-cleaning business.

1997 Seung Hui in the 6th grade continues to be very withdrawn. Teachers meet with his parents about this behavior. In the summer before he enters 7th grade, he begins receiving counseling at the Center for Multicultural Human Services to address his shy, introverted nature, which is diagnosed as "selective mutism." Parents try to socialize him more by encouraging extracurricular activities and friends, but he remains withdrawn.

1999 During the 8th grade, one of Cho's writings for a teacher depicts suicidal and homicidal ideations. The paper references and celebrates the Columbine shootings in April of this year. The school requests that his parents ask a counselor to intervene, which leads to a psychiatric evaluation at the Multicultural Center for Human Services. He is prescribed antidepressant medication. He responds well and is taken off the medication approximately one year later.

2000–2003 (High School)

Fall 2000 Cho starts Westfield High School in Fairfax County as a sophomore, after attending another high school in Centreville for a year. After review by the "local screening committee," he is diagnosed as having an emotional disability and is enrolled in an Individual Educational Program (IEP) to deal with his shyness and lack of responsiveness in a classroom setting. Art therapy (his selective mutism rules out talk therapy as an effective treatment mode) continues with the Multicultural Center for Human Services through his junior year. He has no behavior problems, keeps his appointments, and makes no threats. He gets good grades and adjusts reasonably to the school environment. The guidance office in the school believes he has been academically successful and the therapist notes he has made limited progress in communicating.

June 2003 Cho graduates from Westfield High School with a 3.5 GPA in the Honors Program. He decides to attend Virginia Tech against the advice of his parents and counselors, who think that it is too large a school for him and that he will not receive adequate individual attention. He is given the name of a contact at the high school if he needs help in college, but never avails himself of it.

2003–2004 (Virginia Tech)

August 2003 Cho enters Virginia Tech as a business information systems major. Little attention is drawn to him during his freshman year. He has a difficult time with his roommate over neatness issues and changes rooms. His parents make weekly trips to visit him. His grades are good. He does not see a counselor at school or home. He is excited about college.

Fall 2004 Cho begins his sophomore year. Cho moves off campus to room with a senior who is rarely at home. Cho complains of mites in the apartment, but doctors tell him it is acne and prescribe minocycline. He becomes interested in writing. His grades begin to slip so he decides he will switch his major to English beginning his junior year. His sister notes a growing passion for writing over the winter break, though he is secretive about its content. Cho submits a book idea to a publishing house.

2005 (Virginia Tech)

Spring 2005 Cho requests a change of major to English. The idea for a book sent to a New York publishing house is rejected. This seems to depress him, according to his family. He still sees no counselor at school or

home, and exhibits no behavioral problems other than his quietness.

Fall 2005 Cho starts his junior year and moves back into the dorms. Serious problems begin to surface. His sister notes that he is writing less at home, is less enthusiastic, and wonders if the publisher's rejection letter curbed his enthusiasm for writing. At school, Cho is taken to some parties by his suitemates at the start of the semester. On one such occasion he stabs at the carpet in student Margaret Bowman's room with a knife, in the presence of his suitemates.

October 15 English Professor Nikki Giovanni writes a letter to Cho expressing her concern about his behavior in her class and about violence in his writing. She offers to help get him into another class.

Professor Giovanni asks department chair Dr. Lucinda Roy to remove Cho from her class.

October 18 Dr. Roy informs Mary Ann Lewis, Associate Dean of Liberal Arts and Human Sciences, and others that Cho read a violent and upsetting "poem" in Professor Giovanni's class that day, and that her students said Cho had been surreptitiously taking photos of them. Dr. Roy also says she has contacted Tom Brown (Dean of Student Affairs), Zenobia Hikes (Vice President of Student Affairs), Detective George Jackson at Virginia Tech Police Department (VTPD), and Dr. Robert Miller at the Cook Counseling Center (CCC), to report the incident and seek advice. Tom Brown advises Dr. Roy she can remove Cho from Professor Giovanni's class as long as a viable alternative is offered.

CCC advises that though the "poem" is disturbing, there is no specific threat. They suggest that Cho be referred to the CCC. Frances Keene (Director of Judicial Affairs) and Tom Brown both write to Dr. Roy indicating their concurrence with this plan. Brown tells Dr. Roy to advise Cho that any future similar behavior will be referred [to Judicial Affairs].

October 19 Dr. Roy and Cheryl Ruggiero meet with Cho regarding his situation in Professor Giovanni's class, discuss the impact of his writing on the class, and warn that unauthorized picture-taking is inappropriate, and is taken seriously by Virginia Tech. Cho says his writing was intended as satire and agrees not to take any more photos of classmates or professors. Cho is advised of the study alternative available. He is advised to seek counseling. This is reiterated in an e-mail to Cho following the meeting.

Following the above, Dr. Roy removes Cho from Professor Giovanni's class and tutors him one-on-one with assistance from Professor Frederick D'Aguiar. Cho refuses to go to counseling, and Dr. Roy tells this to the Division of Student Affairs, the CCC, the Schiffert Health Center, the Virginia Tech police, and the College of Liberal Arts and Human Sciences. Cho's problems are discussed at a meeting of Virginia Tech's Care Team that reviews students with problems. Care Team members discuss the arrangement worked out to remove Cho from Professor Giovanni's class and tutor him and that Dr. Roy had met with Cho and documented the results. The Care Team considers the problem solved.

November 2 Cho's roommates and dorm residents think Cho set fires in a dorm lounge and say in emails that they reported it to police. However, no written police report exists.

November 27 Jennifer Nelson, a resident of West Ambler Johnston (WAJ) resident hall in room 4021, files a report with VTPD indicating that Cho has made "annoying" contact with her on the Internet, by phone, and in person. VTPD interviews Cho, but Nelson declines to press charges, though she says she would testify at a disciplinary hearing. The investigating officer refers the incident

to the school's disciplinary system, the Office of Judicial Affairs. The Office of Judiciary Affairs later contacts Nelson, telling her they can only proceed if she files a written complaint. She declines and no hearing is held.

November 30 Cho calls CCC and is triaged (i.e., given a preliminary screening) by phone following his interaction with VTPD.

December 6 E-mails among resident advisors (RAs) reflect complaints by another female student, Christina Lillizu, who lives on the 3rd floor of Cochrane resident hall, regarding derogatory instant messages (IMs) with foul language sent from Cho under various strange aliases. The RAs also report the incidents of IMs Cho to Jennifer Nelson, and his visit in disguise to her dorm room.

Lisa Virga, a resident advisor, sends an e-mail to Rohsaan Settle, a member of the Residence Life staff, detailing a list of complaints about Cho, including a report that he has knives in his room. Virga is concerned that no one in the dorms has confronted Cho directly and she thinks someone should talk to him. Settle responds with an e-mail to Virga saying they should "chat" about the knives.

December 9 Cho sends unwanted IM to a third female student, Margaret Bowman (306 Campbell Hall). Later, he leaves messages on her marker board outside her room.

December 11 Cho leaves a new message, a quote from Shakespeare, on Bowman's marker board.

December 12 Bowman returns from an exam and finds more text added to the message from 12/11. She then files a report with the VTPD complaining of the multiple "disturbing" contacts from Cho. She requests that Cho have no further contact with her. When questioned by students about the notes to Bowman, Cho tells them "Shakespeare did it."

VTPD goes to Cho's room, but he is not there. They leave a message for him with his roommates.

Cho calls and cancels a 2:00 p.m. appointment at CCC but then calls back in the afternoon and is triaged for the second time by phone.

December 13 VTPD notifies Cho that he is to have no further contact with Margaret Bowman. After campus police leave, Cho's suitemate receives an IM from Cho stating, "I might as well kill myself now." The suitemate alerts VTPD. The police take Cho to the VTPD where a prescreener from the New River Valley Community Services Board (CSB) evaluates him as "an imminent danger to self or others." A magistrate issues a temporary detaining order, and Cho is transported to Carilion St. Albans Psychiatric Hospital for an overnight stay and mental evaluation. No one contacts Cho's parents.

December 14

7 a.m. The person assigned as an independent evaluator, psychologist Roy Crouse, evaluates Cho and concludes that he does not present an imminent danger to himself.

Before 11 a.m. A staff psychiatrist at St. Alban's evaluates Cho, concludes he is not a danger to himself or others, and recommends outpatient counseling. He gathers no collateral information.

11–11:30 a.m. Special Justice Paul M. Barnett conducts Cho's commitment hearing and rules in accordance with the independent evaluator, but orders follow-up treatment as an outpatient. Cho then makes an appointment with the CCC and is released.

Noon The St. Alban's staff psychiatrist dictates in his evaluation summary that "there is no indication of psychosis, delu-

sions, suicidal or homicidal ideation." The psychiatrist finds that "his insight and judgment are normal…Follow-up and aftercare to be arranged with the counseling center at Virginia Tech; medications, none."

2:25 p.m. CCC receives a fax from Carilion Health System with copies of the St. Alban's discharge summary and the Pre-admission Screening Form completed by the CSB evaluator the previous day at police headquarters.

3:00 p.m. Cho appears for his appointment and is triaged at the CCC for the third time in 15 days.

Dr. Miller, the CCC director, receives an email notifying him that Cho had been taken to St. Alban's the previous night. Dr. Miller e-mails CCC staff to alert them "in case this student is seen" at the CCC. A CCC staff member e-mails back that Cho already has been seen that afternoon.

2006

January The CCC receives a psychiatric summary from St. Albans. No action is taken by CCC or the Care Team to follow up on Cho.

February Dr. Miller is removed from his position following a management study of the CCC. In his hurry to vacate the office, he packs Cho's file and files of several other students in a box and takes them home. (This is only discovered in July, 2009.)

April 17 Cho's technical writing professor, Carl Bean, suggests that Cho drop his class after repeated efforts to address shortcomings in class and inappropriate choice of writing assignments. Cho follows the professor to his office, raises his voice angrily, and is asked to leave. Professor Bean does not report this incident to Virginia Tech officials.

Spring Cho takes Professor Bob Hicok's creative writing class. Professor Hicok later characterizes Cho's writing as not particularly unique as far as subject matter is concerned, but remarkable for violence.

Fall Cho enrolls in a playwriting workshop taught by Professor Ed Falco. Cho writes a play concerning a young man who hates the students at his school and plans to kill them and himself. The writing contains parallels to the subsequent events of April 16, 2007, as well as the recorded messages sent to NBC that same day.

Professor Falco confers with Professors Roy and Norris, who tell him that in Fall 2005 and in 2006, Dr. Roy and Dr. Norris, respectively, had alerted Associate Dean Mary Ann Lewis about Cho.

September 6–12 Professor Lisa Norris, another of Cho's writing professors, alerts Associate Dean Mary Ann Lewis about him, but the dean finds "no mention of mental health issues or police reports" on Cho. Professor Norris encourages Cho to go to counseling with her, but he declines.

September 26–November 4 Cho writes three more violent stories for an English class.

2007

February 2 Cho orders a .22 caliber Walther P22 handgun online from TGSCOM, Inc.

February 9 Cho picks up the handgun from J-N-D Pawnbrokers in Blacksburg, across the street from Virginia Tech.

March 12 Cho rents a van from Enterprise Rent-A-Car at the Roanoke Regional Airport, which he keeps for almost a month. (Cho videotapes some of his subsequently released diatribe in the van.)

March 13 Cho purchases a 9mm Glock 19 handgun and a box of 50 9mm full metal jacket practice rounds at Roanoke Firearms.

Cho waited the 30 days between gun purchases as required by Virginia law. The store initiates the required background check by police, who find no record of mental health issues.

March 22 Cho goes to PSS Range and Training, an indoor pistol range, and spends an hour practicing.

March 22 Cho purchases two 10-round magazines for the Walther P22 on eBay.

March 23 Cho purchases three additional 10-round magazines from another eBay seller.

March 31 Cho purchases additional ammunition magazines, ammunition, and a hunting knife from Wal-Mart and Dick's Sporting Goods. He buys chains from Home Depot.

Cho gets a speeding ticket, his first police contact since December 2005.

April 7 Cho purchases more ammunition.

April 8 Cho spends the night at the Hampton Inn in Christiansburg, Virginia, videotaping segments for his manifesto-like diatribe. He also buys more ammunition.

April 13 Bomb threats are made to Torgersen, Durham, and Whittemore halls in the form of an anonymous note. The threats are assessed by the VTPD, and the buildings evacuated. There is no lockdown or cancellation of classes elsewhere on campus. Later, during the investigation of the April 16 murders, no evidence is found linking these threats to Cho's bomb threat note in Norris Hall, based in part on handwriting analysis.

April 14 An Asian male wearing a hooded garment is seen by a faculty member in Norris Hall. The faculty member later (after April 16) tells police that one of her students had told her the doors were chained. This may have been Cho practicing. Cho buys yet more ammunition.

April 15 Cho places his weekly Sunday night call to his family in Fairfax County. They report the conversation as normal and that Cho said nothing that caused them concern.

THE INCIDENTS

April 16, 2007

5:00 a.m. In Cho's suite in Harper Hall (2121), one of Cho's suitemates notices Cho is awake and at his computer.

About 5:30 a.m. One of Cho's other suitemates notices Cho clad in boxer shorts and a shirt brushing his teeth and applying acne cream. Cho returns from the bathroom, gets dressed, and leaves.

About 6:45 a.m. Cho is spotted by a student loitering in the foyer area of WAJ resident hall, between the exterior door and the locked interior door. He has access to the mailbox foyer, but not to the interior of the building.

7:02 a.m. Emily Hilscher enters WAJ, her dorm, after being dropped off by her boyfriend, Karl Thornhill. (The time is based on her swipe card record.)

About 7:15 a.m. Cho shoots Hilscher in her room (4040) where he also shoots Ryan Christopher Clark, an RA. Clark, it is thought, most likely came to investigate noises in Hilscher's room, which is next door to his. Both of the victims' wounds ultimately prove to be fatal. Cho exits the scene, leaving behind bloody footprints and shell casings.

7:17 a.m. Cho's access card is swiped at Harper Hall (his nearby residence hall). He goes to his room to change out of his bloody clothes, cancel his computer account, and make other preparations for what is to come.

7:20 a.m. The VTPD receives a call on their administrative telephone line advising that a female student in room 4040 of WAJ had

possibly fallen from her loft bed. The caller was given this information by another WAJ resident near room 4040 who heard the noise.

7:21 a.m. The VTPD dispatcher notifies the Virginia Tech Rescue Squad that a female student had possibly fallen from her loft bed in WAJ.

7:22 a.m. A VTPD officer is dispatched to room 4040 at WAJ to accompany the Virginia Tech Rescue Squad, which is also dispatched per standard protocol.

7:24 a.m. The VTPD officer arrives at WAJ room 4040, finds two people shot inside the room, and immediately requests additional VTPD resources.

7:25 a.m. Cho accesses his university e-mail account (based on computer records). He erases his files and the account.

7:26 a.m. Virginia Tech Rescue Squad 3 arrives on-scene outside WAJ.

7:27 a.m. Police dispatcher is advised of two victims. Officer on scene requests supervisor.

7:29 a.m. Virginia Tech Rescue Squad 3 arrives at room 4040.

7:30 a.m. Additional VTPD officers begin arriving at room 4040. They secure the crime scene and in effect lock down the dormitory, with police inside and outside. Police start preliminary investigation. Interviews with residents fail to produce a suspect description. No one on Hilscher's floor in WAJ saw anyone leave room 4040 after the initial noise was heard.

A housekeeper in Burruss Hall tells Dr. Ed Spencer, Associate Vice President for Student Affairs and member of the Policy Group, that an RA in WAJ was murdered. (The housekeeper had received a phone call from another housekeeper in WAJ.)

7:35 a .m. Police on the scene at WAJ say they need a detective.

7:40 a.m. VTPD Chief Flinchum is notified by phone of the WAJ shootings. Chief Flinchum tries repeatedly to reach the Office of the Executive Vice President.

7:51 a.m. Chief Flinchum contacts the Blacksburg Police Department (BPD) and requests a BPD evidence technician and BPD detective to assist with the investigation.

7:55 a.m. Dr. Spencer arrives at WAJ after walking from Burruss Hall. He calls Dr. Zenobia Hikes.

7:57 a.m. Chief Flinchum finally gets through to the Virginia Tech Office of the Executive Vice President and notifies them of the shootings.

8:00 a.m. Classes begin. Chief Flinchum arrives at WAJ and finds VTPD and BPD detectives on the scene. A local special agent of the Virginia State Police (VSP) has been contacted and is responding to the scene. The VTPD, BPD, and soon the VSP start to process the crime scene in Hilscher's room (4040) and gather evidence. They then canvass the dorm for possible witnesses, search interior and exterior waste containers and surrounding areas near WAJ for evidence, and canvass rescue squad personnel for additional evidence or information.

About 8:00 a.m. The Virginia Tech Center for Professional and Continuing Education locks down on its own.

8:10 a.m. President Steger is notified by a secretary that there has been a shooting. He tells her to get Chief Flinchum on the phone.

8:11 a.m. Chief Flinchum talks to President Steger via phone and reports one student is critical, one is fatally wounded, and the incident seems to be domestic in nature. He reports no weapon found and there are

bloody footprints. President Steger tells Chief Flinchum to keep him informed. A staff member of the Policy Group and President Steger discuss the event, and Steger decides to convene the Policy Group no later than 8:30 a.m.

8:11 a.m. BPD Chief Kim Crannis arrives on scene.

8:13 a.m. Chief Flinchum requests additional VTPD and BPD officers to assist with securing WAJ entrances and with the investigation. He also orders recall of all off-shift personnel.

8:14 a.m. Hilscher's roommate, Heather Hough, arrives at WAJ to go with Hilscher to chemistry class. (Time recorded from swipe card.)

8:15 a.m. Chief Flinchum requests the VTPD Emergency Response Team (ERT) to respond to the scene and then to stage in Blacksburg in the event an arrest is needed or a search warrant is to be executed.

About 8:15 a.m. Two senior officials at Virginia Tech have conversations with family members in which the shooting on campus is related. In one conversation, by phone, the official advised her son, a student at Virginia Tech, to go to class. In the other, in person, the official arranged for extended babysitting.

8:16–8:40 a.m. Hilscher's roommate, Heather Haugh, is interviewed inside WAJ by detectives. She explains that on Monday mornings Hilscher's boyfriend, Karl Thornhill, usually drops her off at WAJ and returns to Radford University where he is a student. She says he owns guns and practices shooting. Police then seek Thornhill as a "person of interest." His vehicle is not found in campus parking lots and officers believe he has left campus. VTPD and BPD officers are sent to his home, but he is not there. The Thornhill home is then put under surveillance until Thornhill is found.

8:16–9:24 a.m. Police continue canvassing WAJ for possible witnesses. VTPD, BPD, and the VSP continue processing Hilscher's room (4040) crime scene and gathering evidence. Investigators secure identification of the victims. Police allow students in WAJ to leave; Some go to 9:00 a.m. classes in Norris Hall.

8:19 a.m. Chief Crannis requests BPD ERT to respond for the same reason as the VTPD ERT.

8:20 a.m. A person fitting Cho's description is seen near the Duck Pond on campus.

8:25 a.m. The Policy Group convenes to plan how to notify students of the double shooting.

Police cancel bank deposit pickups.

8:40 a.m. Chief Flinchum tells President Steger in a phone update that Hilscher's boyfriend is a person of interest and probably off campus. A Policy Group member notifies the Governor's office of the double shooting.

8:40–8:45 a.m. Phone calls are made from BPD to its units and to Montgomery County Sheriff's Office and Radford University police to be on the lookout for Thornhill's vehicle.

8:45 a.m. A Policy Group member e-mails a Richmond colleague saying one student is dead and another critically wounded. "Gunman on the loose," he says, adding "This is not releasable yet."

8:49 a.m. The same Policy Group member reminds his Richmond colleague, "just try to make sure it doesn't get out."

8:50 a.m. First period classes end. The Policy Group begins composing a notice to the university about the shootings in WAJ. The Associate Vice President for University Relations, Larry Hincker, is unable to send the message at first due to technical difficulties with the alert system.

8:52 a.m. Blacksburg public schools lock down until more information is available about the incident at Virginia Tech. School superintendent notifies school board of this by e-mail.

The Executive Director of Government Relations, Ralph Byers, directs that the doors to his office be locked. It is adjacent to the President's suite, but the four doors to the President's suite remain open.

9:00-9:15 a.m. Virginia Tech veterinary college locks down.

9:01 a.m. Cho mails a package from the Blacksburg post office to NBC News in New York that contains pictures of himself holding weapons, an 1,800-word rambling diatribe, and video clips in which he expresses rage, resentment, and a desire to get even with oppressors. He alludes to a coming massacre. Cho prepared this material in the previous weeks. The videos are a performance of the enclosed writings. Cho also mails a letter to the English Department attacking Professor Carl Bean, with whom he previously argued.

9:05 a.m. Classes begin for the second period in Norris Hall.

Virginia Tech trash pickup is cancelled.

9:15 a.m. Both police ERTs are staged at the BPD in anticipation of executing search warrants or making an arrest.

9:15–9:30 a.m. Cho is seen outside and then inside Norris Hall, an engineering building, by several students. He is familiar with the building because one of his classes meets there. He chains the doors shut on the three public entrances, from the inside. No one reports seeing him do this. A faculty member finds a bomb threat note attached to an inner door near one of the chained exterior doors. She gives it to a janitor to carry to the Engineering School dean's office on the third floor.

9:24 a.m. A Montgomery County deputy sheriff initiates a traffic stop of Hilscher's boyfriend in his pickup truck off campus. He had heard there had been a shooting and was driving back to the campus to search for Hilscher after she did not answer his calls. Detectives are sent to assist with the questioning.

A VTPD police captain joins the Policy Group as police liaison and provides updates as information becomes available. He reports one gunman at large, possibly on foot.

9:26 a.m. Virginia Tech administration sends e-mail to campus staff, faculty, and students informing them of the dormitory shooting.

About 9:30a.m. Radford University Police had received a request from BPD to look up Thornhill's class schedule and find him in class. Before they can do this they get a second call that he has been found and stopped on the road.

9:30 a.m. Police pass information to the Policy Group that it is unlikely that Hilscher's boyfriend, Thornhill, is the shooter (though he remains a person of interest).

9:31–9:48 a.m. A VSP trooper arrives at the traffic stop of Thornhill and helps question him. A gunpowder residue test is performed and packaged for lab analysis. (There is no immediate result from this type of test in the field.)

About 9:40 a.m.–9:51 a.m. Cho begins shooting in room 206 in Norris Hall, where a graduate engineering class in Advanced Hydrology is underway. Cho kills Professor G. V. Loganathan and other students in the class, killing 9 and wounding 3 of the 13 students.

Cho goes across the hall from room 206 and enters room 207, an Elementary German class. He shoots teacher Christopher James Bishop, then students near the front of the classroom and starts down the aisle shoot-

ing others. Cho leaves the classroom to go back into the hall.

Students in room 205, attending Haiyan Cheng's class on Issues in Scientific Computing, hear Cho's gunshots. (Cheng was a graduate assistant substituting for the professor that day.) The students barricade the door and prevent Cho's entry despite his firing at them through the door.

Meanwhile, in room 211 Madame Jocelyne Couture-Nowak is teaching French. She and her class hear the shots, and she asks student Colin Goddard to call 9-1-1. A student tells the teacher to put the desk in front of the door, which is done, but it is nudged open by Cho. Cho walks down the rows of desks shooting people. Goddard is shot in the leg. Student Emily Haas picks up the cell phone Goddard dropped. She begs the police to hurry. Cho hears Haas and shoots her, grazing her twice in the head. She falls and plays dead, though keeping the phone cradled under her head and the line open. Cho says nothing on entering the room or during the shooting. (Three students who pretend to be dead survive.)

9:41 a.m. A BPD dispatcher receives a call regarding the shooting in Norris Hall. The dispatcher initially has difficulty understanding the location of the shooting. Once identified as being on campus, the call is transferred to VTPD.

9:42 a.m. The first 9-1-1 call reporting shots fired reaches the VTPD. A message is sent to all county EMS units to staff and respond.

9:45 a.m. The first police officers arrive at Norris Hall, a three-minute response time from their receipt of the call. Hearing shots, they pause briefly to check whether they are being fired upon, then rush to one entrance, and then another but find the doors chained shut. An attempt to shoot open the chain or lock on one door fails.

About 9:45 a.m. The police inform the administration that there has been another shooting. Virginia Tech President Steger hears sounds like gunshots, and sees police running toward Norris Hall.

Back in room 207, the German class, two uninjured students and two injured students go to the door and hold it shut with their feet and hands, keeping their bodies away. Within 2 minutes, Cho returns. He beats on the door and opens it an inch and fires shots around the door handle, then gives up trying to get in.

Cho returns to room 211, the French class, and goes up one aisle and down another, shooting people again. Cho shoots Goddard two more times.

A janitor sees Cho in the hall on the second floor loading his gun; the janitor flees downstairs.

Cho tries to enter room 204 where engineering professor Liviu Librescu is teaching Mechanics. Professor Librescu braces his body against the door yelling for students to head for the window. He is shot through the door. Students push out screens and jump or drop to grass or bushes below the window. Ten students escape this way. The next two students trying to escape are shot. Cho returns again to room 206 and shoots more students.

9:50 a.m. Using a shotgun, police shoot open the ordinary key lock of a Norris Hall entrance that goes to a machine shop and that could not be chained. These officers hear gunshots as they enter the building.

They immediately follow the sounds to the second floor.

Triage and rescue of victims begin.

A second e-mail is sent by the administration to all Virginia Tech e-mail addresses announcing that "A gunman is loose on campus. Stay in buildings until further notice. Stay away from all windows." Four outside loudspeakers on poles broadcast a similar message.

Virginia Tech and Blacksburg police ERTs arrive at Norris Hall, including one paramedic with each team.

9:51 a.m. Cho shoots himself in the head just as police reach the second floor. Investigators believe that the police shotgun blast alerted Cho to police (starting entry into the building). Cho's shooting spree in Norris Hall lasted about 11 minutes. He fired 174 rounds, and killed 30 people in Norris Hall plus himself, and wounded 17.

The first team of officers begins securing the second floor and aiding survivors from multiple classrooms. They also get a preliminary description of the suspected gunman, and try to determine if there are additional gunmen.

9:52 a.m. The police clear the second floor of Norris Hall. Two tactical medics attached to the ERTs, one medic from Virginia Tech Rescue and one from Blacksburg Rescue, are allowed to enter to start their initial triage.

9:53 a.m. The 9:42 a.m. request for all EMS units is repeated.

10:08 a.m. A deceased male student is discovered by police team and suspected to be the gunman:

- No identification is found on the body.
- He appears to have a self-inflicted gunshot wound to the head.
- He is found among his victims in classroom 211, the French class.
- Two weapons are found near the body.

10:17 a.m. A third e-mail from Virginia Tech administration cancels classes and advises people to stay where they are.

10:51 a.m. All patients from Norris Hall have been transported to a hospital or moved to a minor treatment unit.

10:52 a.m. A fourth e-mail from Virginia Tech administration warns of "a multiple shooting with multiple victims in Norris Hall," saying "the shooter is in custody" and that as routine procedure police are searching for a second shooter.

10:57 a.m. A report of shots fired at the tennis courts near Cassell Coliseum proves false.

12:42 p.m. Virginia Tech President Charles Steger announces that police are releasing people from buildings and that counseling centers are being established.

1:35 p.m. A report of a possible gunshot near Duck Pond proves to be another false alarm.

4:01 p.m. President George W. Bush speaks to the Nation from the White House regarding the shooting.

5:00 p.m. The first deceased victim is transported to the medical examiner's office.

8:45 p.m. The last deceased victim is transported to the medical examiner's office.

Evening Police continue investigating whether Karl Thornhill, Emily Hilscher's boyfriend, is linked to her murder and that of Ryan Clark because the ballistics analysis that later ties together the WAJ and the Norris Hall murders (confirming that Cho's guns were used at both incidents) is not yet completed. The Blacksburg ERT, including Virginia Tech and Montgomery County Po-

lice, enters Thornhill's home and searches it. The ERT searches his residence. Using standard procedures, ERT members handcuff Thornhill and his family who have come to console him. They are put on the floor while the search is made, because Thornhill is known to own firearms. The search is highly upsetting to Thornhill and his family.

POST-INCIDENT

April 17, 2007

9:15 a.m. VTPD releases the name of the shooter as Seung Hui Cho and confirms 33 fatalities between the two incidents.

9:30 a.m. Virginia Tech announces classes will be cancelled "for the remainder of the week to allow students the time they need to grieve and seek assistance as needed."

11:00 a.m. A family assistance center is established at The Inn at Virginia Tech.

2:00 p.m. A convocation ceremony is held for the university community at the Cassell Coliseum. Speakers include President George W. Bush, Virginia Governor Tim Kaine (who had returned from Japan), Virginia Tech President Charles Steger, Virginia Tech Vice President for Student Affairs Zenobia L. Hikes, local religious leaders (representing the Muslim, Buddhist, Jewish, and Christian communities), Provost Dr. Mark G. McNamee, Dean of Students Tom Brown, Counselor Dr. Christopher Flynn, and poet Professor Nikki Giovanni.

8:00 p.m. A candlelight vigil is held on the Virginia Tech drill field.

11:30 p.m. The first autopsy is completed.

April 18, 2007

8:25 a.m. A SWAT team enters Burruss Hall, a campus building next to Norris Hall, responding to a "suspicious event"; this proves to be a false alarm.

4:37 p.m. Local police announce that NBC News in New York just received by mail a package containing images of Cho holding weapons, his writings, and his video recordings. NBC immediately submitted this information to the FBI. A fragment of the video and pictures are widely broadcast.

April 19, 2007

Virginia Tech announces that all students who were killed will be granted posthumous degrees in the fields in which they were studying. The degrees are subsequently awarded to the families at the regular commencement exercises, or privately, or in one case, at a Corps of Cadets event in Fall 2007.

Governor Kaine appoints an independent Virginia Tech Review Panel to review the shootings.

Autopsies on all victims are completed by the medical examiner. The autopsy of Cho found no gross brain function abnormalities and no toxic substances, drugs, or alcohol that could explain the rampage.

April 20, 2007

Governor Kaine declares a statewide day of mourning.

Chapter IV.
MENTAL HEALTH HISTORY OF SEUNG HUI CHO

This chapter is divided into two parts: Part A, the mental health history of Cho, and Part B, a discussion of Virginia's mental health laws.

Part A – Mental Health History of Seung Hui Cho

One of the major charges Governor Kaine gave to the panel was to develop a profile of Cho and his mental health history. In this chapter, developmental periods of Cho's life are discussed, followed by an assessment and recommendations to address policy gaps or system flaws. The chapter details his involuntary commitment for mental health treatment while at Virginia Tech. It also examines the particular warning signs during Cho's junior year at Virginia Tech and the university's ability to identify and respond appropriately to students who may present a danger to themselves and others.

Information was gleaned from many sources. One of the most significant was a 3-hour interview with Cho's parents and sister. The family stated that they were willing to help in any way with the panel's work, and felt incapable of redressing the loss for other families. They expressed heartfelt remorse, and they apologized to the families whose spouse, son, or daughter was murdered or injured. The Cho's have said that they will mourn, until the day they die, the deaths and injuries of those who suffered at the hands of their son.

Cho's sister, Sun, interpreted the answers to every question posed to Mr. and Mrs. Cho. At the end of the interview, they had portrayed the person they knew as a son and brother, someone who was startlingly different from the one who carried out premeditated murder.

Other sources of information included:

- Hundreds of pages of transcripts and records from Westfield High School, Virginia Tech, and various medical offices and mental health treatment centers.
- Interviews with high school staff and administrators where Cho attended school, faculty and staff at Virginia Tech, and several of Cho's suitemates, roommates, and resident advisors in the dormitories.
- Interviews with staff at the Center for Multicultural Human Services, the Cook Counseling Center, the Carilion Health System, special justices, and Virginia Tech police.
- The tape and written records of Cho's hearing before special justice Barnett.
- The report of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, *Investigation of April 16, 2007 Critical Incident at Virginia Tech.*

EARLY YEARS

Cho was born in Korea on January 18, 1984, the second child of Sung-Tae Cho and Hyang Im Cho. Both parents were raised in two-parent families that included the paternal grandmother; there was extended family support. The families did not encounter the level of deprivation that many did in post-war Korea. The Chos recall that a paternal uncle in Korea committed suicide. Their first child, daughter Sun Kyung, was born 3 years before Seung Hui.

When he was 9 months old, Cho developed whooping cough, then pneumonia, and was hospitalized. Doctors told the Chos that their son had a hole in his heart (some records say "heart murmur"). Two years later, doctors conducted cardiac tests to better examine the inside of his heart that included a procedure (probably an

echocardiograph or a cardiac catherization). This caused the 3-year-old emotional trauma. From that point on, Cho did not like to be touched. He generally was perceived as medically frail. According to his mother, he cried a lot and was constantly sick.

In Korea, Cho had a few friends that he would play with and who would come over to the house. He was extremely quiet but had a sweet nature. In Korea, quietness and calmness are desired attributes—characteristics equated with scholarliness; even so, his introverted personality was so extreme that his family was very concerned.

In 1992, the family moved to the United States to pursue educational opportunities for their children. They were encouraged by Mr. Cho's sister who had immigrated before them. Mrs. Cho began working outside the home for the first time in order to make ends meet. The transition was difficult: none of the family spoke English. Both children felt isolated. The parents began a long period of hard labor and extended work hours at dry cleaning businesses. English was not required to do their work, so both there and at home they spoke Korean.

Sun stated that her brother seemed more withdrawn and isolated in the United States than he had been in Korea. She recalled that at times they were "made fun of," but she took it in stride because she thought "this was just a given." In about 2 years, the children began to understand, read, and write English at school. Korean was spoken at home, but Cho did not write or read Korean.

For the first 6 months in the United States, the Chos lived with family members in Maryland. They moved to a townhouse for 1 year, after which they relocated to Virginia, living in an apartment for 3 years. The move to Virginia occurred in the middle of third grade for Cho. He was 9 years old. Cho's only known friendship was with a boy next door with whom he went swimming.

Sun and her parents recall that Cho seemed to be doing better. He was enrolled in a Tae Kwon Do program for awhile, watched TV, and played video games like Sonic the Hedgehog. None of the video games were war games or had violent themes. He liked basketball and had a collection of figurines and remote controlled cars. Years later when he was in high school, Cho was asked to write about his hobbies and interests. He wrote:

> I like to listen to talk shows and alternative stations, and I like action movies…My favorite movie is X-Men, favorite actor is Nicolas Cage, favorite book is *Night Over Water*, favorite band is U2, favorite sport is basketball, favorite team is Portland Trailblazers, favorite food is pizza, and favorite color is green.

Transportation to and from extracurricular activities was a problem because both parents worked long hours trying to save money to buy a townhouse, which they accomplished a few years later. The parents recalled that Cho had to wait for transport back and forth all the time.

The parents reported no disciplinary problems with their son. He was quiet and gentle and did not exhibit tantrums or angry outbursts. The family never owned weapons or had any in the house. At one point after Cho was in college, his mother found a pocket knife in one of his drawers, and she expressed her disapproval. He had few duties or responsibilities at home, except to clean his room. He never had a job during summers or over school breaks, either in high school or in college.

The biggest issue between Cho and his family was his poor communication, which was frustrating and worrisome to them. Over the years, Cho spoke very little to his parents and avoided eye contact. According to one record the panel reviewed, Mrs. Cho would get so frustrated she would shake him sometimes. He would talk to his sister a little, but avoided discussing his feelings and reactions to things or sharing everyday thoughts on life, school, and events. If called upon to speak when a visitor came to the home, he would develop sweaty palms, become pale, freeze, and sometimes cry. Frequently, he would only nod yes or no.

Mrs. Cho made a big effort to help Cho become better adjusted, and she would talk to him, urging him to open up, to "have more courage." The parents urged him to get involved in activities and sports. They worried that he was isolating himself and was lonely. Other family members asked why he would not talk. He reportedly resented this pressure. Mr. Cho, having a quiet nature himself, was slightly more accepting of his son's introspective and withdrawn personality, but he was stern on matters of respect. Cho and his father would argue about this. According to one of the records reviewed, Cho's father would not praise his son. Where Cho's later writings included a father-son relationship, the character of the father was always negative. Cho never talked about school and never shared much. His mother and sister would ask how he was doing in school, trying to explore the possibility of "bullying." His sister knew that when he walked down school hallways a few students sometimes would yell taunts at him. He did not talk about feelings or school at all. He would respond "okay" to all questions about his well being.

Cho, as a special needs child, generated a high level of stress within the family. Adaptation to cope with this stress can produce both positive and negative results. The family dynamic which evolved in the Chos' to cope with this stress was that of "rescue" behavior and more coddling of Cho who seemed unreachable emotionally. There was some friction between Cho and his sister, however, nothing that appeared as other than normal sibling rivalry. In fact, Sun was the one to whom Cho spoke the most.

Key Findings of Early Years

- Cho's early development was characterized by physical illness and inordinate shyness.
- Even as a young boy, Cho preferred not to speak, a situation that worried and frustrated his parents.
- He was ostracized by some peers, though he did not discuss this with his family.
- His parents worked very long hours and had financial difficulties. They worried about the effect of this on their children because they had less than optimum time to devote to parenting.
- Medical records did not indicate a diagnosis of mental illness prior to coming to the United States.

ELEMENTARY SCHOOL IN VIRGINIA

Cho was enrolled in the English as a Second Language (ESL) program in Virginia as soon as he arrived in the middle of third grade. The family at this time was living in a small apartment. School teachers indicated that Cho would not "interact socially, communicate verbally, or participate in group activities." One teacher reported that he did play with one student during recess.

Cho was referred to the school's educational screening committee because teachers believed his communication problems stemmed more from emotional issues than from language barriers. When Cho was in sixth grade, his parents bought a townhouse next to the school so he could easily commute to his classes. The school requested a parent–teacher conference because Cho was not answering any questions in class. Mrs. Cho took an interpreter with her to the parent-teacher conference. She resolved to "find" friends for him and encouraged both their children to go to the church she attended. Because the congregation was small, however, there were few children, so both Cho and his sister lost interest and stopped going to church.

One of Mrs. Cho's friends urged her to look into another church that reportedly had a minister who "could help people with problems like Cho's." She occasionally attended that church over a 6-month period, but decided against reaching out to that pastor to work with her son. Several newspaper articles that appeared after the shooting reported that the pastor from that church had worked directly with Cho. According to Mrs. Cho, those reports are untrue. Mrs. Cho did register her son for a 1-week summer basketball camp

sponsored by that church, but she never sought its help on personal matters.

Mrs. Cho tried to be extra nurturing to Cho. He did not reject her attempts at socialization *per se*, but he disliked talking. Finally, Cho's parents decided to "let him be the way he is" and not force him to interact and talk with others. He never spoke of imaginary friends. He did not seem to be involved in a fantasy world or to be preoccupied by themes in his play or work that caused concern. He never talked of a "twin brother." The parents' characterization of him was a "very gentle, very tender," and "good person."

MIDDLE SCHOOL YEARS

The summer before Cho started seventh grade, his parents followed up on a recommendation from the elementary school that they seek therapy for Cho. In July 1997, the Cho's took their son to the Center for Multicultural Human Services (CMHS), a mental health services facility that offers mental health treatment and psychological evaluations and testing to low-income, English-limited immigrant and refugee individuals. They told the specialists of their concern about Cho's social isolation and unwillingness to discuss his thoughts or feelings.

Mr. and Mrs. Cho overcame several obstacles to get their son the help he needed. In order for Cho to make his weekly appointments at the center, they had to take turns leaving work early to drive him there. There were cultural barriers as well. In the family's native country, mental or emotional problems were signs of shame and guilt. The stigmatization of mental health problems remains a serious roadblock in seeking treatment in the United States too, but in Korea the issue is even more relevant. Getting help for such concerns is only reluctantly acknowledged as necessary.

After starting with a Korean counselor with whom there was a poor fit, Cho began working with another specialist who had special training in art therapy as a way of diagnosing and addressing the emotional pain and psychological problems of clients. Typically, this form of therapy is used with younger children who do not have sufficient language or cognitive skills to utilize traditional "talk" therapy. Because Cho would not converse and uttered only a couple words in response to questions, art therapy was one way to reach him. The specialist offered clay modeling, painting, drawing, and a sand table at each session. Cho would choose one of the options. As he worked, the therapist could ascertain how he was feeling and what his creations might represent about his inner world. Then she talked to him about what his work indicated and hoped to help him progress in being more socially functional. He modeled houses out of clay, houses that had no windows or doors.

Cho's therapist noted that while explaining the meaning of Cho's artwork to him, his eyes sometimes filled with tears. She never saw anything that he wrote. Eventually, Cho began to make eye contact. She saw this as a start toward becoming healthier.

Cho also had a psychiatrist who participated in the first meeting with Cho and his family and periodically over the next few years. He was diagnosed as having [severe] "social anxiety disorder." "It was painful to see," recalled one of the psychiatrists involved with Cho's case. The parents were told that many of Cho's problems were rooted in acculturation challenges—not fitting in and difficulty with friends. Personnel at the center also noted in his chart that he had experienced medical problems and that medical tests as an infant and as a preschooler had caused emotional trauma. Records sent to Cho's school at the time (following a release signed by his parents) and the tests administered by mental health professionals evaluated Cho to be a much younger person than his actual age, which indicated social immaturity, lack of verbal skills, but not retardation. His tested IQ was above average.

Cho continued to isolate himself in middle school. He had no reported behavioral problems and did not get into any fights. Then, in March 1999, when Cho was in the spring semester of eighth

grade, his art therapist observed a change in his behavior. He began depicting tunnels and caves in his art. In and of themselves, those symbols were not cause for alarm, but Cho also suddenly became more withdrawn and showed symptoms of depression. In that context, the therapist felt that the tunnels and caves were red flags. She was concerned and asked him whether he had any suicidal or homicidal thoughts. He denied having them, but she drew up a contract with him anyway, spelling out that he would do no harm to himself or to others, and she told him to communicate with his parents or someone at school if he did experience any ideas about violence. That is just what he did, in the form of a paper he wrote in class.

The following month, April 1999, the murders at Columbine High School occurred. Shortly thereafter, Cho wrote a disturbing paper in English class that drew quick reaction from his teacher. Cho's written words expressed generalized thoughts of suicide and homicide, indicating that "he wanted to repeat Columbine," according to someone familiar with the situation. No one in particular was named or targeted in the words he wrote. The school contacted Cho's sister since she spoke English and explained what had happened. The family was urged to have Cho evaluated by a psychiatrist. The sister relayed this information to her parents who asked her to accompany Cho to his next therapy appointment and report the incident, which she did. The therapist then contacted the psychiatrist for an evaluation.

Cho was evaluated in June 1999 by a psychiatrist at the Center for Multicultural Human Services. There, psychiatric interns from The George Washington University Hospital provide treatment one day a week supervised by other doctors at GWU. Cho was fortunate because the intern who was his psychiatrist was actually an experienced child psychiatrist and family counselor who had practiced in South America prior to coming to the United States. He had to recertify in this country and was in the process of doing that at GWU Hospital when he first met Cho.

Mr. and Mrs. Cho explained to the psychiatrist that they were facing a family crisis since their daughter would be leaving home in the fall to attend college and she was the family member with whom Cho communicated, as limited as that communication was. They feared that once their daughter was no longer home, he would not communicate at all. The psychiatrist also was informed of the disturbing paper Cho had written.

The doctor diagnosed Cho with "selective mutism" and "major depression: single episode." He prescribed the antidepressant Paroxetine 20 mg, which Cho took from June 1999 to July 2000. Cho did quite well on this regimen; he seemed to be in a good mood, looked brighter, and smiled more. The doctor stopped the medication because Cho improved and no longer needed the antidepressant.

Selective mutism is a type of an anxiety disorder that is characterized by a consistent failure to speak in specific social situations where there is an expectation of speaking. The unwillingness to speak is not secondary to speech/communication problems, but, rather, is based on painful shyness. Children with selective mutism are usually inhibited, withdrawn, and anxious with an obsessive fear of hearing their own voice. Sometimes they show passive-aggressive, stubborn and controlling traits. The association between this disorder and autism is unclear.

Major depression refers to a predominant mood of sadness or irritability that lasts for a significant period of time accompanied by sleep and appetite disturbances, concentration problems, suicidal ideations and pervasive lack of pleasure and energy. Major depression typically interferes with social, occupational and educational functioning. Effective treatments for depression and selective mutism include psychotherapy and anti depressants/anti-anxiety agents such as Selective Serotonin Reuptake Inhibitors (SSRI's).

It should be noted that when the subject of Cho's eighth grade paper and subsequent evaluation was discussed with Mr. and Mrs. Cho and Cho's

sister during the interview, they appeared shocked to learn that he had written about violence toward others. They said they knew he had hinted at ideas about suicide, but not about homicide.

School records indicate that an interpreter was provided (sometimes this was Cho's sister) during meetings that involved the parents, as is the policy and required by law.

HIGH SCHOOL YEARS

In fall of 1999, Cho began high school at Centreville High School. The following year a new school, Westfield High School, opened to accommodate the population growth in that part of Fairfax County. Cho was assigned there for his remaining 3 years. About 1 month after classes began at Westfield, one of Cho's teachers reported to the guidance office that Cho's speech was barely audible and he did not respond in complete sentences. The teacher wrote that he was not verbally interactive at all and was shy and shut down. There was practically no communication with teachers or peers. Those failings aside, teachers also praised Cho for his qualities as a student. He achieved high grades, was always on time for class, and was diligent in submitting well-done homework assignments. Other than failing to speak, he did not exhibit any other unusual behaviors and did not cause problems. When the teacher asked Cho if he would like help with communicating, he nodded yes.

The guidance counselors asked Cho whether he had ever received mental health or special education assistance in middle school or in his freshman year (at the previous high school), and he reportedly indicated (untruthfully) that he had not.

Cho's situation was brought before Westfield's Screening Committee on October 25, 2000, for evaluation to determine if he required special education accommodations. Federal law requires that schools receiving federal funding enable children with disabilities to learn in the least restrictive environment and to be mainstreamed in classrooms. Provisions are made for special services or accommodations after a core evaluation involving a battery of tests is given to diagnose the problems and to guide the school in preparing an Individualized Education Plan (IEP). The high school conducted a special assessment to rule out autism as an underlying factor. Cho also was evaluated in the following domains:

Psychological
Sociocultural
Educational
Speech/Language
Hearing Screening
Medical
Vision

As part of the assessment process, school personnel met with Cho's parents to find out more about his history and to explain the assessment process. Mrs. Cho expressed concern about how her son would fare later in college given the transition required and his poor social skills. She noted that her son was receiving counseling and gave permission for the school to contact her son's therapist. The therapist, in turn, was encouraged by the fact that the school would be tracking Cho's progress. The committee determined that Cho was eligible for the Special Education Program for Emotional Disabilities and Speech and Language. Mr. and Mrs. Cho were receptive to receiving help for him and so was his older sister who was in college and with whom he had a good relationship. The parents and sister continued to be in contact with the school; Sun usually served as interpreter.

Special accommodations were made to help Cho succeed in class without frustration or intimidation. The school developed an IEP, as required by law that was effective in January 2001. The IEP listed two curriculum and classroom accommodations and modifications: modification for oral presentations, as needed, and modified grading scale for oral or group participation. In-school language therapy was recommended as well, but Cho only received that service once a month for 50 minutes. His art therapist, who reached out to a few teachers and others at the school with

questions or concerns, said she asked why the language therapy was so limited. The school responded that it was reluctant to pull him out of class for this special service because this would interrupt his academic work or negatively impact his grades. Besides, the primary diagnosis was selective mutism, not problems with the mechanics of speaking or an inability to function in English.

Cho was encouraged to join a club and to stay after school for help from teachers. He was permitted to eat lunch alone and to provide verbal responses in private sessions with teachers rather than in front of the whole class where his manner of speaking and accent sometimes drew derision from peers.

With this arrangement, Cho's grades were excellent. He had advanced placement and honors classes. However, his voice was literally inaudible in class, and he would only whisper if pushed (an observation consistent with his behavior later in college). In written responses, at times, his thinking appeared confused and his sentence structure was not fluent. Indeed, his guidance counselor raised the question to the panel: "Why did he change his major to English at Tech?" Why did this student, whose forte appeared to be science and math, switch to humanities?

After the Virginia Tech murders, some newspapers reported that Cho was the subject of bullying. The panel could not confirm whether or not he was bullied or threatened. His family said that he never mentioned being the target of threats or intimidating messages, but then neither did he routinely discuss any details about school or the events of his day. His guidance counselor had no records of bullying or harassment complaints.

Nearly all students experience some level of bullying in schools today. Much of this behavior occurs behind the scenes or off school grounds—and often electronically, through instant messaging, communications on MySpace and, to a lesser extent, on Facebook, a website used by older teenagers. Cho's high school counselor could not say whether bullying might have occurred before or after school, as suggested by other unconfirmed sources.

It would be reasonable, however, to assume that Cho was a victim of some bullying, though to what extent and how much above the norm is not known. His sister said that both of them were subjected to a certain level of harassment when they first came to the United States and throughout their school years, but she indicated that it was neither particularly threatening nor ongoing.

In the eleventh grade, Cho's weekly sessions at the mental health center came to an end because there was a gradual, if slight, improvement over the years and he resisted continuing, according to his parents and therapist "There is nothing wrong with me. Why do I have to go?" he complained to his parents. Mr. and Mrs. Cho were not happy that their son chose to discontinue treatment, but he was turning 18 the following month and legally he could make that decision.

Cho took upper level science and math courses and spent 3 to 4 hours a day on homework. He earned high marks and finished high school with a grade point average of 3.52 in an honors program. That GPA, along with his SAT scores (540 for verbal and 620 for math registered in the 2002 testing year) were the basis for his acceptance at Virginia Tech. What the admission's staff at Virginia Tech did not see were the special accommodations that propped up Cho and his grades. Those scores reflected Cho's knowledge and intelligence, but they did not reflect another component of grades: class participation. Since that aspect of grading was substantially modified for Cho due to the legally mandated accommodations for his emotional disability, his grades appeared higher than they otherwise would have been.

When his guidance counselor talked to Cho and his family about college, she strongly recommended they send him to a small school close to home where he could more easily make the transition to college life. She cautioned that Virginia Tech was too large. However, Cho appeared very self-directed and independent in his decision. He

chose Virginia Tech, which had been his goal for some time. He applied and was accepted.

Virginia Tech does not require an essay or letters of recommendation in the freshman application package and does not conduct personal interviews. Acceptance decisions at Virginia Tech are based primarily on grades and SAT scores, though demographics, interests, and some intangibles are also considered. An essay about oneself is optional. Cho included a short writing about rock climbing in his application, which was written in the first person and spoke about human potential that often cannot be achieved because of self-doubt.

Before Cho left high school, the guidance counselor made sure that Cho had the name and contact information of a school district resource who Cho could call if he encountered problems at college. As is now known, Cho never sought that help while at Virginia Tech.

As Cho looked to the fall of 2003, he was preparing to leave home for the first time and enter an environment where he knew no one. He was not on any medication for anxiety or depression, had stopped counseling, and no longer had special accommodations for his selective mutism. Neither Cho nor his high school revealed that he had been receiving special education services as an emotionally disabled student, so no one at the university ever became aware of these pre-existing conditions.

There is a standard cover page that accompanied Cho's transcripts to Virginia Tech called "Pupil Permanent Record, Category 1". The page lists all the types of student records, whether they include information from elementary, middle, or high school, and how long they are to be retained. The lower right corner of the page has a section marked "The Student Scholastic Record" under which are boxes to be checked as they apply. The first six boxes are Clinic, Cumulative, Discipline, Due Process, Law Enforcement, and Legal. Only the first two were checked, indicating Cho had no records pertaining to discipline or legal problems. Then, there is a subheading labeled "Special Services Files" where six additional boxes are presented: Contract Services, ESL, 504 Plan, Gifted and Talented, Homebound, and Special Education. Only the ESL box is checked, even though Cho had special education services. The special education services box was not checked.

As the panel reviewed Cho's mental health records and conducted interviews with persons who had provided psychiatric and counseling services to Cho throughout his public school career, it became evident that critical records from one public institution are not necessarily transferred to the next as a person matures and enters into new stages of development. What are the rules regarding the release of special education records between, for example, high schools and colleges?

It is common practice to require students entering a new school, college, or university to present records of immunization. Why not records of serious emotional or mental problem too? For that matter, why not records of all communicable diseases?

The answer is obvious: personal privacy. And while the panel respects this answer, it is important to examine the extent to which such information is altogether banned or could be released at the institution's discretion. No one wants to stigmatize a person or deny her or him opportunities because of mental or physical disability. Still, there are issues of public safety. That is why immunization records must be submitted to each new institution. But there are other significant threats facing students beyond measles, mumps, or polio.

The panel asked its legal counsel to review the laws pertaining to special education records and the release of that information, specifically as addressed in FERPA and the Americans with Disabilities Act (ADA). Although FERPA generally allows secondary schools to disclose educational records (including special education records) to a university, federal disability law prohibits universities from making what is known as a 'preadmission inquiry" about an applicant's disability status. After admission, however, universities

may make inquiries on a confidential basis as to disabilities that may require accommodation.

It should be noted that the Department of Education's March 2007 "Transition of Students with Disabilities to Post Secondary Education: A Guide for High School Educators" clarifies that a high school student has no obligation to inform an institution of post secondary education that he or she has a disability; however, if the student wants an academic adjustment, the student must identify himself or herself as having a disability. Cho did not seek any accommodations from Virginia Tech. The disclosure of a disability is always voluntary.

It is a more subtle question whether Fairfax County Public Schools would have had to remove any indication of special education status or accommodation from Cho's transcript or grade reports as part of his college application.

Because this issue is of such great importance and because much more study is needed, the panel does not make a recommendation here. But the panel hopes that this issue begins to be debated fully in the public realm. Perhaps students should be required to submit records of emotional or mental disturbance and any communicable diseases *after they have been admitted but before they enroll at a college or university,* with assurance that the records will not be accessed unless the institution's threat assessment team (by whatever name it is known) judges a student to pose a potential threat to self or others.

Or perhaps an institution whose threat assessment team determines that a student is a danger to self or others should promptly contact the student's family or high school, inform them of the assessment, and inquire as to a previous history of emotional or mental disturbance.

This much is clear: information critical to public safety should not stay behind as a person moves from school to school. Students may start fresh in college, but their history may well remain relevant. Maybe there really should be some form of "permanent record."

Key Findings of Cho's School Years

- Both the family and the schools recognized that Cho's problem was not merely introversion and that Cho needed therapy to help with extreme social anxiety, as well as acculturation and communication.
- A depressive phase in the second half of eighth grade led to full blown depression and thoughts of suicide and homicide precipitated by the Columbine shooting. Cho received timely psychiatric assessment and intervention (prescription of Paroxetine and continued therapy). This episode abated within a year, and medications were discontinued.
- Transportation problems interfered with Cho's involvement with sports and extracurricular activities, which may have increased his isolation.
- Intervention for a child suffering from mental illness reduces the burden of illness as well as the risk for severe outcomes such as violence and suicide, as it did for Cho during his pre-college years.
- During his high school years, Cho was identified as having special educational needs. His identification as a special education student within the first 9 weeks of enrollment in a new high school and the accommodations accorded him as part of his Individualized Educational Plan led to a high degree of academic success. Indeed, his high school guidance counselor felt that his high school career was a success. With regard to his social skills, however, his progress was minimal at best.
- Clearly, Cho appeared to be at high risk, as withdrawn and inhibited behavior confers risk. This risk seemed mitigated by the interventions and accommodations put in place by the school. This risk also was reduced by involved and concerned parents who were particular in following through with weekly therapy. This risk was further mitigated by effective therapy that allowed expression (through

art therapy) of underlying feelings of inadequacy. These factors as well as an above-average performance in school (buttressed by accommodations) lessened his frustration and anger.

- The school that Cho attended played an important part in reducing the possibility of severe regression in his functioning. The school worked closely with Cho's parents and sister. There was coordination between the school and the therapist and the psychiatrist who were treating Cho. These positive influences ended when Cho graduated from high school. His multifaceted support system then disappeared leaving a huge void.

COLLEGE YEARS

In August of 2003, Cho began classes at Virginia Tech as a Business Information Technology major. Mr. and Mrs. Cho were concerned about his move away from home and the stress of the new environment, especially when they learned he was unhappy with his roommate. His parents visited him every weekend on Sundays during that first semester, which was a major time commitment since they both worked the other 6 days of the week. They noted that the dorm room trash can was full of beer cans (allegedly, from the interview with Cho's parents, the roommate was drinking) and the room was quite dirty. Cho, in contrast, had kept his room neat at home and had good hygiene. He requested a room change—a move that his parents and sister saw as a positive sign that he was being proactive and taking care of his own affairs. It seemed as though college was working out for him because he seemed excited about it.

Cho settled in, got his room changed by the beginning of the second semester, and seemed to be adjusting. Parental visits became less frequent. According to a routine they established, every Sunday night he spoke with his parents by telephone who always asked how he was doing and whether he needed anything, including money. Mr. and Mrs. Cho said that he never asked for extra money and would not accept any. He was very mindful of the family's financial situation and lived frugally. He would not buy things even though his parents encouraged him occasionally to purchase new clothes or other items. They reported that he did not appear envious or angry about anything.

During his freshman year, Cho took courses in biology, math, communications, political science, business information systems, and introduction to poetry. His grades overall were good, and he ended the year with a GPA of 3.00.

Cho's sophomore year (2004–2005) brought some changes. Cho made arrangements to share the rent on a condominium with a senior at Virginia Tech who worked long hours and was rarely home. His courses that fall leaned more heavily toward science and math. His grades slipped that term. At the same time, he became enthusiastic about writing and decided he would switch his major to English beginning the fall semester of 2005. It is unclear why he made this choice as he disliked using words in school or at home. Moreover, English had not been one of his strongest subjects in high school.

The answer may be found in an exchange of e-mails that Cho had with then-Chair of the English Department, Dr. Lucinda Roy. Cho had taken one of her poetry classes, a large group, entry-level course the previous semester. On Saturday, November 6, 2004, he wrote "I was in your poetry class last semester, and I remember you talking about the books you published. I'm looking for a publisher to submit my novel…I was just wondering if you know of a lot of publishers or agents or if you have a good connection with them." He went on, "My novel is relative[ly] short…sort of like Tom Sawyer except that it's really silly and pathetic depending on how you look at it.…" Dr. Roy's first e-mail back said: "Could you send me your name? You forgot to sign your note." "Seung Cho," he wrote. Dr. Roy then recommended two resource books and gave him tips on finding literary agents. She also advised, "If you haven't yet

taken a creative writing (fiction) course…you should consider doing so."

University personnel explained to the panel that Virginia Tech's process for changing majors relies on "advisors" who serve to help ensure that students are taking the right number of credits and courses to meet the requirements of their major and to graduate. They do not generally offer counsel on whether a student is making a wise move or examine the reasons behind their class choices. In any given year at Virginia Tech, many students change majors. Over 40 percent of the student body changes their major after the first year or two. Thus this change is not abnormal and not a red flag.

Cho seemed to enjoy the idea of writing, especially poetry. His sister noticed that he would bring home stacks of books on literature and poetry and books on how to become a writer. Writing seemed to have become a passion, and his family was thrilled that he found something he could be truly excited about. He would spend hours at his computer writing, but when his sister asked to see his work, he would refuse. On one rare occasion, she did get to read a story he wrote about a boy and his imaginary friend, which she thought was somewhat strange, but nothing too odd.

Cho's parents never read his compositions, both because he did not offer to show them and because they did not read English, at least not well.

Cho took three English courses in the spring of 2005, plus an economics course, and an introductory psychology course. He did not do particularly well, especially in the literature courses. One of his English professors gave him a D-, another, a C+. He earned a B+ in Introduction to Critical Reading, but also withdrew from the economics class, thus earning only 12 credits and registering a 2.32 for the semester.

Late that sophomore year, in his presence, Cho's sister chanced upon a rejection letter from a New York publishing house on Cho's desk at home. He had submitted a topic for a book describing the book's outline. She encouraged him to continue to write and learn saying that all writers have to work at their craft for a long time before they are published and that he was just at the beginning and not to lose heart.

While living in the off-campus condominium, Cho became convinced that he had mite bites (based on searches he did on the Internet). He went to a local doctor who diagnosed it as severe acne and put him on medication. Other than followup appointments for his acne at home and at the Shiffert Medical Center at Virginia Tech (he continued to believe mites were the problem), he did not have regular appointments with general practitioners, specialists, psychiatrists, or counselors in his hometown during his entire college tenure. His family reported that he came home for all his breaks and would spend the time writing, reading, playing basketball, and riding his bike—alone.

Storm Clouds Gathering, Fall 2005 – The fall semester of Cho's junior year (2005) was a pivotal time. From that point forward, Cho would become known to a growing number of students and faculty not only for his extremely withdrawn personality and complete lack of interest in responding to others in and out of the classroom, but for hostile, even violent writings along with threatening behavior.

He registered for French and four English courses, one of which was Creative Writing: Poetry, taught by Nikki Giovanni. It would seem he selected this course on the basis of Dr. Roy's advice to him the previous fall. His sister began noticing some subtle changes: he was not writing as much in his junior year and he seemed more withdrawn. The family wondered whether he was getting anxious about the future and what he would do after graduation. His father wanted him to go to graduate school, but Cho indicated he did not want to continue with academics after he graduated. His parents then offered to help him find a job after graduation, but he refused.

Cho had moved back to the dormitories that semester. He had a roommate and two suitemates

who lived in another room connected by a bathroom—a typical layout in the residence halls. The panel interviewed his roommate and one suitemate who related some events from that year. They described Cho in the same way as he is described throughout this report: very quiet, short responses to questions, and rarely initiating any communication. At the beginning of the school year, the roommate and the other suitemates took Cho to several parties. He would always end up sitting in the corner by himself. One time they all went back to a female student's room. Cho took out a knife ("lock blade, not real large") and started stabbing the carpet. They stopped taking him out with them after that incident.

The three suitemates would invite Cho to eat with them at the beginning of the year, but he would never talk so they stopped asking. They observed him eating alone in the dining hall or lounge. The roommate asked Cho who he hung out with and Cho said "nobody." He would see him sometimes at the gym playing basketball by himself or working out.

Cho's roommate never saw him play video games. He would get movies from the library and watch them on his laptop. The roommate never saw what they were, but they always seemed dark. Cho would listen to and download heavy metal music. Someone wrote heavy metal lyrics on the walls of their suite in the fall, and then in the halls in the spring. Several of the students believed Cho was responsible because the words were similar to the lyrics Cho posted on Facebook.

Several times when the suitemates came in the room, it smelled as though Cho had been burning something. One time they found burnt pages under a sofa cushion. Cho would go to different lounges and call one of the suitemates on the phone. He would identify himself as "question mark"—Cho's twin brother—and ask to speak with Seung. He also posted messages to his roommate's Facebook page, identifying himself as Cho's twin. The roommate saw a prescription drug bottle on his desk. He and the others in the suite looked it up online and found that it was a medication for "skin fungus."

Cho's actions in the poetry class taught by Nikki Giovanni that semester are widely known and documented. For the first 6 weeks of class, the professor put up with Cho's lack of cooperation and disruptive behavior. He wore reflector glasses and a hat pulled down to obscure his face. Dr. Giovanni reported to the panel that she would have to take time away from teaching at the beginning of each class to ask him to please take off his hat and please take off his glasses. She would have to stand beside his desk until he complied. Then he started wearing a scarf wrapped around his head, "Bedouin-style" according to Professor Giovanni. She felt that he was trying to bully her.

Cho also was uncooperative in presenting and changing the pieces that he wrote. He would read from his desk in a voice that could not be heard. When Dr. Giovanni would ask him to make changes, he would present the same thing the following week. One of the papers he read aloud was very dark, with violent emotions. The paper was titled "So-Called Advanced Creative Writing – Poetry." He was angry because the class had spent time talking about eating animals instead of about poetry, so his composition, which he would later characterize as a satire, spoke of an "animal massacre butcher shop."

In the paper, Cho accused the other students in the class of eating animals, "I don't know which uncouth, low-life planet you come from but you disgust me. In fact, you all disgust me." He made up gruesome quotes from the classmates, then wrote, "You low-life barbarians make me sick to the stomach that I wanna barf over my new shoes. If you despicable human beings who are all disgraces to [the] human race keep this up, before you know it you will turn into cannibals—eating little babies, your friends,. I hope y'all burn in hell for mass murdering and eating all those little animals."

Dr. Giovanni began noticing that fewer students were attending class, which had never been a

problem for her before. She asked a student what was going on and he said, "It's the boy…everyone's afraid of him." That was when she learned that Cho also had been using his cell phone to take pictures of students without permission.

Dr. Giovanni talked to Cho, telling him, "I don't think I'm the teacher for you," and offered to get him into another class. He said that he did not want to transfer, which surprised her. She contacted the head of the English Department, Dr. Roy, about Cho and warned that if he were not removed from her class, she would resign. He was not just a difficult student, she related, he was not working at all. Dr. Giovanni was offered security, but declined saying she did not want him back in class, period. She saw him once on campus after that and he just stared at the ground.

Dr. Roy explained to the panel what her actions were once Dr. Giovanni made her aware of Cho's upsetting behavior. She remembered Cho from the previous semester when he took that poetry class she taught (she had given him a B- in the course). Dr. Roy contacted the Dean of Student Affairs, Tom Brown, the Cook Counseling Center, and the College of Liberal Arts with regard to the objectionable writing that Dr. Giovanni showed Dr. Roy. She asked to have it evaluated from a psychological point of view and inquired about whether the picture-taking might have been against the code of student conduct.

Dean Brown sent an e-mail message to Dr. Roy and advised "there is no specific policy related to cell phones in class. But, in Section 2 of the *University Policy for Student Life*, item #6 speaks to disruption. This is the 'disorderly conduct' section which reads: 'Behavior that disrupts or interferes with the orderly function of the university, disturbs the peace, or interferes with the performance of the duties of university personnel.' Clearly, the disruption he caused falls under this policy if adjudicated."

Dean Brown also said, "I talked with a counselor…and shared the content of the 'poem'… and she did not pick up on a specific threat. She suggested a referral to Cook during your meeting. I also spoke with Frances Keene, Judicial Affairs director and she agrees with your plan." He continued, "I would make it clear to him that any similar behavior in the future will be referred."

Frances Keene noted in her response to Dean Brown and Dr. Roy that she was available if Cho had any further questions about how using his cell phone in class to take photographs could constitute disorderly conduct. She also wrote, "I agree that the content is inappropriate and alarming but doesn't contain a threat to anyone's immediate safety (thus, not actionable under the abusive conduct – threats section of the UPSL)."

During an interview with the panel, Ms. Keene related that she would have needed something in writing to initiate an investigation into the disorderly conduct violation, and reported that she never received anything. The formal request would have come from the English Department.

Ms. Keene recalled that the concern about Cho was brought before the university's "Care Team," of which she is a member, at their regular meeting. The Care Team is comprised of the dean of Student Affairs, the director of Residence Life, the head of Judicial Affairs, Student Health, and legal counsel. Other agencies from the university are occasionally asked to participate; including the Women's Center, fraternities and sororities, the Disability Center, and campus police, though these agencies are not standing members of the Team.

At the Care Team meeting, members were advised of the situation with Cho and that Dr. Roy and Dr. Giovanni wanted to proceed with a class change to address the matter. The perception was that the situation was taken care of and Cho was not discussed again by the Care Team. The team made no referrals of Cho to the Cook Counseling Center. The Care Team did nothing. There were no referrals to the Care Team later that fall semester when Resident Life, and later, VTPD became

aware of Cho's unwanted communications to female students and threatening behavior.

Frances Keene said that she received no communications from the female students who had registered complaints about Cho and that she learned of those incidents only through campus police incident reports. However, the assistant director of Judicial Affairs, Rohsaan Settle, received an e-mail communication on December 6 advising her of Cho's "odd behavior" and "stalking." Ms. Keene indicated that it is her office's policy to contact students who have been threatened and advise them of their rights, but one of the students stated that she was never contacted by Judicial Affairs, and there is no documentation that the others were contacted. Ms. Keene indicated that she would have discussed these incidents with the Care Team at the time the incidents occurred had she known about them.

Dr. Roy e-mailed Cho and asked him to contact her for a meeting. He responded with an angry, two-page letter in which he harshly criticized Dr. Giovanni and her teaching, saying she would cancel class and would not really instruct, but just have students read what they wrote and discuss the writings. He agreed to meet with Dr. Roy and said "I know it's all my fault because of my personality…Being quiet, one would think, would repel attention but I seem to get more attention than I want (I can just tell by the way people stare at me)." He said he imagined she was going to "yell at me."

Dr. Roy asked a colleague, Cheryl Ruggiero, to be present for the meeting with Cho. Ms. Ruggiero took notes, the transcription of which provided an exceptionally detailed account of that session with Cho as did e-mails from Dr. Roy to appropriate administration officials after the meeting.

Cho arrived wearing dark sunglasses. He seemed depressed, lonely, and very troubled. Dr. Roy assured him she was not going to yell at him, but discussed the seriousness of what he wrote and his other actions. He replied that he was "just joking" about the writing in Giovanni's class, but agreed that it might have been perceived differently. Dr. Roy asked him if he was offended by the class discussion on eating animals and he said, "I wasn't offended. I was just making fun of it…thought it was funny, thought I'd make fun of it." He was asked if he was a vegetarian or had religious beliefs about eating meat or animals; he answered no to both questions.

Ms. Ruggiero's transcript mentions that Dr. Roy "proposes alternative of working independently with herself and Fred D'Aguiar." The transcript also notes that Cho "doesn't want to lose credits…if not 'kicked out' will stay" [*I (Ruggiero) noted some emotion on the words 'kicked out,' a small spark of anger or resentment]*. The transcript goes on to document that "Lucinda asked if he would remove his sunglasses." Cho takes a long time to respond, but he does remove them. "It is a very distressing sight, since his face seems very naked and blank without them. It's a great relief to be able to read his face, though there isn't much there." Dr. Roy asks if taking off the sunglasses has been terrible for him…and says "he doesn't seem like himself, like the student she knew in the Intro to Poetry class, and she asks if anything terrible or bad has happened to him." Eventually Cho answers "No."

Twice during the meeting with Cho, Dr. Roy asked him if he would talk to a counselor. She told him she had the name of someone, and asked again if he would consider going. He did not answer for a while, and then said vaguely, "sure."

In her interview with the panel, Dr. Roy stated that the university's policy made the situation difficult. She was obligated to offer Cho an alternative that was equivalent to the instruction he would receive in Giovanni's class. Thus, she offered to tutor him privately. He later agreed. She told Cho that he would have to meet four more times and do some writing. As he left the meeting, Dr. Roy gave him a copy of her book. He took it and "appeared to be crying," she related.

Throughout the deliberations about Cho's writing and behavior and the available options, Dr. Roy communicated widely with all relevant university

officers and provided updates on meetings and decisions. On October 19, 2005, Dr. Roy e-mailed Zenobia Hikes, Tom Brown, George Jackson, and Robert Miller with a report on her meeting with Cho.

> Cheryl and I met with the student we spoke about today. We spoke about 30 minutes. He was very quiet and it took him long time to respond to question; but I think he may be willing to work with me and with Professor Fred D'Aguiar rather than continuing in Nikki's course…h e didn't seem to think that his poem should have alarmed anyone… [But] he also said he understood *why* people assumed from the piece that he was angry with them. I strongly recommended that he see a counselor, and he didn't commit to that one way or the other. …Both Cheryl and I are genuinely concerned about him because he *appeared* to be very depressed—though of course only a professional could verify that.

One month later, Dr. Roy wrote to Associate Dean Mary Ann Lewis, Liberal Arts & Human Sciences, who in turn shared it with the dean of Student Affairs and Ellen Plummer, Assistant Provost and Director of the Women's Center. She wrote

> He is now meeting regularly with me and with Fred D'Aguiar rather than with Nikki. This has gone reasonably well, though all of his submissions so far have been about shooting or harming people because he's angered by their authority or by their behavior. We're hoping he'll be able to write inside a different kind of narrative in the future, and we're encouraging him to do so…I have to admit that I'm still very worried about this student. He still insists on wearing highly reflective sunglasses and some responses take several minutes to elicit. (I'm learning patience!) But I am also impressed by his writing skills, and by what he knows about poetry when he opens up a little. I know he is very angry, however, and I am encouraging him to see a counselor—something he's resisted so far. Please let me and Fred know if you see a problem with this approach.

For the remainder of the semester, Dr. Roy focused on William Butler Yeats and Emily Dickinson to help him develop empathy toward others and redirect his writing away from violent themes. They worked on a poem together where she went over technical skills. She saw no overt threats in the writings he did for her. He was stiff, sad, and seemed deliberately inarticulate, but gradually he opened up and wrote well. She repeatedly offered to take him to counseling. She eventually gave him an "A" for a grade.

Cho did not go home for Thanksgiving, according to his roommate and resident advisor, though he thought that Cho may have gone home for a few days at Christmas. When Cho's parents were asked about this they indicated that he came home at every break, but that sometimes he would have to wait a day or so until their day off work so they could come pick him up at school.

According a VTPD incident report, on Sunday, November 27, the police, following a complaint from a female student who lived on the fourth floor of West Ambler Johnston, came to Cho's room to talk to him. The roommate went to the lounge and then returned after the police left. Cho said "want to know why the police were here?" He then related that "he had been text messaging a female student and thought it was a game". He went to her room wearing sunglasses and a hat pulled down and said "I'm question mark." He said that "the student freaked out," and the resident advisor came out and called the police. According to the police record, the officer warned Cho not to bother the female student anymore, and told him they would refer the case to Judicial Affairs.

The resident advisor told the panel about Cho, "He was strange and got stranger." She said that Cho's roommate and one of the other suitemates found a very large knife in Cho's desk and discarded it.

On Wednesday, November 30, at 9:45 am, Cho called Cook Counseling Center and spoke with Maisha Smith, a licensed professional counselor. This is the first record of Cho's acting upon professors' advice to seek counseling, and it followed

the interaction he had had with campus police three days before. She conducted a telephone triage to collect the necessary data to evaluate the level of intervention required. Ms. Smith has no independent recollection of Cho and her notes from the triage are missing from Cho's file. A note attached to the electronic appointment indicates that Cho specifically requested an appointment with Cathye Betzel, a licensed clinical psychologist, and indicated that his professor had spoken with Dr. Betzel. The appointment was scheduled for December 12 at 2:00 pm, but Cho failed to keep the appointment. However, he did call Cook Counseling after 4:00 pm that same afternoon and was again scheduled for telephone triage.

According to the Cook scheduling program documents, Cho was again triaged by telephone at 4:45 on December 12. This triage was conducted by Dr. Betzel who has no recollection of the specific content of the "brief triage appointment." Written documentation that would have typically been completed at that time is missing. The "ticket" completed to indicate the type of contact indicates that the telephone appointment was kept, that no diagnosis was made (consistent with Cook's procedure to not make a diagnosis until a clinical intake interview is completed) and that no referral was made for follow-up services either at Cook or elsewhere. Dr. Betzel did recall at the time of her interview with the panel that she had a conversation with Dr. Roy concerning a student whose name she did not recall, however the details were so similar that she believes it was Cho. She recalls that Dr. Roy was concerned about disturbing writings submitted by Cho in class, and that Dr. Roy detailed her plans to meet with the student individually. The date of Dr. Betzel's consultation with Dr. Roy is unknown and any written documentation that would typically have been associated with the consultation is missing from Cho's file.

CHO'S HOSPITALIZATION AND COMMITMENT PROCEEDINGS

(The law pertaining to these proceedings is discussed in Part B of this chapter.)

On December 12, 2005, the Virginia Tech Police Department (VTPD) received a complaint from a female sophomore residing in the East Campbell residence hall regarding Cho. She knew Cho through his roommate and suitemate. The students had attended parties together at the beginning of the semester and it was at this young woman's room that Cho had produced a knife and stabbed the carpet. While the student no longer saw Cho socially, she had received instant messages and postings to her Facebook page throughout the semester that she believed were from him. The messages were not threatening, but, rather, self-deprecating. She would write back in a positive tone and inquire if she were responding to Cho. The reply would be "I do not know who I am." In early December, she found a quote from *Romeo and Juliet* written on the white erase board outside her dorm room. It read:

> *By a name*
> *I know not how to tell thee who I am*
> *My name, dear saint is hateful to myself*
> *Because it is an enemy to thee*
> *Had I it written, I would tear the word*

The young woman shared with her father her concerns about the communications that she believed were from Cho. The father spoke with his friend, the chief of police for Christiansburg, who advised that the campus police should be informed.

The following day, December 13, a campus police officer met with Cho and instructed him to have no further contact with the young woman. She did not file criminal charges. No one spoke with her regarding her right to file a complaint with Judicial Affairs. Records document that there were multiple e-mail communications regarding the incident among Virginia Tech residential staff, the residence life administrator on call, and the president's & upper quad area coordinator, the director of Residence Life, and the assistant director of Judicial Affairs. The matter was not, however,

brought before the Virginia Tech multi-disciplinary Care Team.

Following the visit from the police, Cho sent an instant message to one of his suitemates stating "I might as well kill myself." The suitemate reported the communication to the VTPD.

Police officers returned around 7:00 p.m. that same day to interview Cho again in his dorm room. The suitemate was not present, but they spoke to Cho's roommate out of his presence. The officers took Cho to VTPD for assessment, and a pre-screen evaluation was conducted there at 8:15 p.m. by a licensed clinical social worker for New River Valley Community Services Board (CSB). The pre-screener interviewed Cho and the police officer, and then spoke with both Cho's roommate and a suitemate by phone. She recorded her findings on a five-page Uniform Pre-Admission Screening Form, checking the findings boxes indicating that Cho was mentally ill, was an imminent danger to self or others, and was not willing to be treated voluntarily. She recommended involuntary hospitalization and indicated that the CSB could assist with treatment and discharge planning. She located a psychiatric bed, as required by state law at St. Albans Behavioral Health Center of the Carilion New River Valley Medical Center (St. Albans) and contacted the magistrate by phone to request that a temporary detention order (TDO) be issued.

The magistrate considered the pre-screen findings and issued a TDO at 10:12 p.m. Police officers transported Cho to St. Albans where he was admitted at 11:00 p.m. Cho did not speak at all with the officer during the trip to the hospital. He was noted to be cooperative with the admitting process. The diagnosis on the admission orders was "Mood Disorder, NOS" [non specific]. On the Carilion Health Services screening form for the potential for violence, it was marked that Cho denied any prior history of violent behavior, but that he did have access to a firearm. (The panel inquired about this, and checking the box for firearm access may have been an error.) He was on no medication at the time of admission, but Ativan was prescribed for anxiety, as needed. One milligram of Ativan was administered at 11:40 p.m. (The records do not show that he ever received another dose.) Cho passed an uneventful night according to the nursing notes.

On the morning of December 14, at approximately 6:30 a.m., the Clinical Support Representative for St. Albans met with Cho to give him information about the mental health hearing. Around 7:00 a.m., the representative escorted Cho to meet with a licensed clinical psychologist, who conducted an independent evaluation of Cho pursuant to Virginia law.

The independent evaluator reported to the panel that he reviewed the prescreening report, but that due to the early hour, there were no hospital records available for his review. He did not speak with the designated attending psychiatrist who had not yet seen Cho. The evaluator has no specific recollection, but believes that the independent evaluation took approximately 15 minutes.

The evaluator completed the evaluation form certifying his findings that Cho "is mentally ill; that he does not present an imminent danger to (himself/others), or is not substantially unable to care for himself, as a result of mental illness; and that he does not require involuntary hospitalization." The independent evaluator did not attend the commitment hearing; however, both counsel for Cho and the special justice signed off on the form certifying his findings.

Shortly before the commitment hearing, the attending psychiatrist at St. Albans evaluated Cho. When he was interviewed by the panel, the psychiatrist did not recall anything remarkable about Cho, other than that he was extremely quiet. The psychiatrist did not discern dangerousness in Cho, and, as noted, his assessment did not differ from that of the independent evaluator—that Cho was not a danger to himself or others. He suggested that Cho be treated on an outpatient basis with counseling. No medications were prescribed, and no primary diagnosis was made.

The psychiatrist's conclusion was based in part on Cho's denying any drug or alcohol problems or any previous mental health treatment. The psychiatrist acknowledged that he did not gather any collateral information or information to refute the data obtained by the pre-screener on the basis of which the commitment was obtained. He indicated that this is standard practice and that privacy laws impede the gathering of collateral information. (Chapter V discusses these information privacy laws in detail.) The psychiatrist also said that the time it takes to gather collateral information is prohibitive in terms of existing resources.

Freer access to clinical information among agencies is imperative so that a rational plan for treatment can be developed. As for the relationship between the independent evaluator and the staff psychiatrist, they rarely see each other and they function independently. The role of the independent evaluator is to provide information to the court and the job of the attending psychiatrist is to provide clinical care for the patient.

As for counseling services at Virginia Tech and the other area universities from which St. Albans Hospital receives patients, according to the psychiatrist they are all stretched for mental health resources. The lack of outpatient providers who can develop a post-discharge treatment plan of substance is a major flaw in the current system. The lack of services is common in both the public and the private outpatient sectors.

The psychiatrist noted his recommendation for outpatient counseling on the Initial Consent Form for TDO Admissions. The clinical support representative then escorted Cho and other TDO patients to meet with their attorney prior to their hearings. There were four hearings that morning, and the attorney has no specific recollection of Cho.

A special justice designated by the Circuit Court of Montgomery County presided over the commitment hearing for Cho held shortly after 11:00 a.m. on December 14. Neither Cho's suitemate nor his roommate nor the detaining police officer nor the pre-screener nor the independent evaluator nor the attending psychiatrist attended the hearing. The prescreening report was read into the record by Cho's attorney. The special justice reviewed the independent evaluation form completed by the independent evaluator and the treating psychiatrist's recommendation. He heard evidence from Cho. The special justice ruled that Cho "presents an imminent danger to himself as a result of mental illness" and ordered "O-P" (outpatient treatment) "—to follow all recommended treatments."

The clinical support representative (CSR) contacted Cook Counseling Center at Virginia Tech to make an appointment for Cho. The Cook Counseling Center required that Cho be put on the phone (a practice begun shortly before this hearing according to the CSR) to make the appointment, which he did. The appointment was scheduled for 3:00 p.m. that afternoon, December 14. The CSR does not recall whether this phone call was made prior to or following the hearing.

The clinical support representative recalls making his customary phone call to New River Valley CSB to advise them of the outcome of the morning's hearings. It was not the hospital's practice at that time to send copies of the orders from the commitment hearings.

Due to the rapidly approaching outpatient appointment for Cho, the CSR urged the treating psychiatrist to expedite the dictation and transcription of his discharge summary. It was transcribed shortly before noon and the physical evaluation findings and recommendation about an hour later. The clinical support representative recalls faxing the records to Cook Counseling Center, but he did not place a copy of the transmittal confirmation in the hospital records. Cook Counseling Center, however, has no record of having received any hospital records until January 2006. The physical evaluation report indicated that Cho was to be treated by the psychiatrist at St. Albans "and hopefully have some intervention in therapy for treatment of his mood disorder." The discharge

summary, which was not part of the records received by the panel from Cook Counseling Center, indicated "followup and aftercare to be arranged with counseling center at Virginia Tech. Medications none."

Cho was discharged from St. Albans at 2:00 p.m. on December 14. No one the panel interviewed could say how Cho got back to campus. However, the electronic scheduling program at the Cook Counseling Center indicates that Cho kept his appointment that day at 3:00 p.m. He was triaged again, this time face-to-face, but no diagnosis was given. The triage report is missing (as well as those from his two prior phone triages), and the counselor who performed the triage has no independent recollection of Cho. It is her standard practice to complete appropriate forms and write a note to document critical information, recommendations, and plans for followup.

It is unclear why Cho would have been triaged for a third time rather than receiving a treatment session at his afternoon appointment following release from St. Albans. The *Collegiate Times* had run an article at the beginning of the fall semester expressing "concern about the diminished services provided by the counseling center" and the temporary loss of its only psychiatrist.

It was the policy of the Cook Counseling Center to allow patients to decide whether to make a followup appointment. According to the existing Cook Counseling Center records, none was ever scheduled by Cho. Because Cook Counseling Center had accepted Cho as a voluntary patient, no notice was given to the CSB, the court, St. Albans, or Virginia Tech officials that Cho never returned to Cook Counseling Center.

AFTER HOSPITALIZATION

Cho's family did not realize what was happening with him at Blacksburg that fall 2005 semester: his dark writings, stalking, and other odd and unsettling behavior that worried roommates, resident advisors, teachers and eventually, campus police. They were unaware that their son had been committed for a time to St. Albans Hospital or that he had appeared in court before a special justice. This is corroborated by documents and interviews relating that Cho refused to notify his parents when campus police responded to his threat of suicide. The university did not inform the parents either.

According to Virginia Tech records, there was a "home town" doctor or counselor who Cho could see when he was home. The panel did not discover what led to this assumption. However, it is known that the university did not contact the family to ascertain the veracity of home town followup for counseling and medication management.

When Cho's parents were asked what they would have done if they had heard from the college about the professors', roommates, and female students' complaints, their response was, "We would have taken him home and made him miss a semester to get this looked at …but we just did not know… about anything being wrong." From their history during the high school years, we do know that they were dedicated to getting him to therapy consistently and also consented to psychopharmacology when the need arose.

More Problems, Spring 2006 – The trend of disturbing themes continued to be apparent in many of Cho's writings, along with his selective mutism.

Robert Hicok had Cho in his Fiction Workshop class that semester. Hicok described his class as a mid-level fiction course with about 20 students. He told the panel that there was no participation from Cho and that Cho's stories and work were violent. He said Cho was a very cogent writer, but his creativity was not that good. Cho was open to suggestions and he made some edits, but he was "not very unique" in his writing. The combination of the content of Cho's stories and his not talking raised red flags for Hicok. He consulted with Dr. Roy, but then decided to keep Cho in the class and just deal with him. Hicok scheduled two meetings with Cho, but he did not show up, and Hicok never saw Cho again after the semester ended. Cho received a D+ in this class.

Professor Hicok shared none of Cho's writings with the panel. However, based on a question to a panel member by a reporter, further inquiry was made as this report was about to go to press. Several writings by Cho in Hicok's class were produced, one of which is of particular significance. It tells the story of a morning in the life of Bud "who gets out of bed unusually early…puts on his black jeans, a strappy black vest with many pockets, a black hat, a large dark sunglasses [sic] and a flimsy jacket…." At school he observes "students strut inside smiling, laughing, embracing each other….A few eyes glance at Bud but without the glint of recognition. I hate this! I hate all these frauds! I hate my life….This is it….This is when you damn people die with me…." He enters the nearly empty halls "and goes to an arbitrary classroom…." Inside "(e)veryone is smiling and laughing as if they're in heaven-on-earth, something magical and enchanting about all the people's intrinsic nature that Bud will never experience." He breaks away and runs to the bathroom "I can't do this….I have no moral right…." The story continues by relating that he is approached by a "gothic girl." He tells her "I'm nothing. I'm a loser. I can't do anything. I was going to kill every god damn person in this damn school, swear to god I was, but I…couldn't. I just couldn't. Damn it I hate myself!" He and the "gothic girl" drive to her home in a stolen car. "If I get stopped by a cop my life will be forever over. A stolen car, two hand guns, and a sawed off shotgun." At her house, she retrieves "a .8 caliber automatic rifle and a M16 machine gun." The story concludes with the line "You and me. We can fight to claim our deserving throne."

Cho encountered problems in another English class that semester, Technical Writing, taught by Carl Bean. The professor told the panel that Cho was always very quiet, always wore his cap pulled down, and spoke extremely softly. Bean opined that "this was his power." By speaking so softly, he manipulated people into feeling sorry for him and his fellow students would allow him to get credit for group projects without having worked on them. Bean noted that Cho derived satisfaction from learning "how to play the game—do as little as he needed to do to get by." This profile of Cho stands in contrast to the profile of a pitiable, emotionally disabled young man, but it may in fact represent a true picture of the other side of Cho—the one that murdered 32 people.

Bean allowed that Cho was very intelligent. He could write with technical proficiency and could read well. However, his creative writing skills were limited and his command of the English language was "very impoverished." He had trouble with verb tenses and use of articles. On two or three occasions early in the semester, Bean had spoken to Cho after class regarding the fact that he was not participating orally nor working collaboratively on group assignments. By late March or early April, the class was given a writing assignment to do a technical essay about a subject within their major. Cho suggested George Washington and the American Revolution, but Bean advised him that this was not within his major. Cho next suggested the April 1960 revolution in Korea—again rejected because the topic was not in his major. Cho then decided to write "an objective real-time" experience based on *Macbeth* and corresponding to serial killings.

On April 17, 2006, one school year prior to the shooting to the day (because it was also a Monday), Bean asked Cho to stay after class again. The professor explained to Cho that his work was not satisfactory and that his topic was not acceptable. He recommended that Cho drop the class and that he would recommend that a late drop be permitted. Cho never said a word, just stared at him. Then, without invitation, Cho followed Bean to his office. The professor offered for him to sit down, but Cho refused and proceeded to argue loudly that he did not want to drop the class. Bean was surprised because he had never heard Cho speak like that before nor engage in that type of conduct. He asked Cho to leave his office and return when he had better control of himself. Cho left and subsequently sent an e-mail advising that he had dropped the course.

Bean did not discuss the matter with Dr. Roy and he was not aware that Nikki Giovanni had encountered problems with Cho the prior semester. After the massacre of April 16, it was discovered that Cho had mailed a letter to the English Department on that same day. Bean stated he knew Cho was antisocial, manipulative, and intelligent. Cho, he said, had obviously "researched" Bean after dropping Bean's course, because in the April 16 letter Cho wrote numerous times that Bean "went holocaust on me." Bean has a great interest in the Holocaust.

Fall 2006 – Cho enrolled in Professor Ed Falco's playwriting workshop in the fall semester. During the first class when each student was asked to introduce him/herself to the class, Cho got up and left before his turn. When he returned for the second class, Professor Falco informed him that he would have to participate; Cho did not respond. In his interview with the panel, Professor Falco described Cho's writing as juvenile with some pieces venting anger.

Post April 16, 2007 students from this class were quoted in the campus newspaper as saying that some class members had joked that they were waiting for Cho to do something. One student reportedly had told a friend that Cho "was the kind of guy who might go on a rampage killing".

According to an article in the August 10, 2007 edition of *The Roanoke Times*, Professor Falco, director of Virginia Tech's creative writing program, recently proposed and participated in the drafting of written guidelines for dealing with students who submit disturbing and violent work. The guidelines suggest that faculty concerned about a student's writing pursue a series of actions including speaking to the student, encouraging the student to seek counseling, and involving university administrators.

Cho also took a class called "Contemporary Horror" in the fall of 2006. His final exam paper which appears to analyze a horror film is reasonable and cogent. The professor awarded Cho a B for the course.

Cho's senior year roommate explained to the panel that he tried speaking to Cho at the beginning of the semester, but Cho barely responded. "I hardly knew the guy; we just slept in the same room." Cho went to bed early and got up early, so his roommate just left him alone and gave him his space. The only activities Cho engaged in were studying, sleeping, and downloading music. He never saw him play a video game, which he thought strange since he and most other students play them. One of the suitemates mentioned that he saw Cho working out at McCommis Hall and saw him return to the room from time to time in workout attire. Cho kept his side of the room very neat. Nothing appeared to be abnormal—no knives, guns, chains, etc. The only reading material the roommate saw on Cho's side was a paperback copy of the New Testament, which he thought may have been for a class. (Cho took a course in the spring 2007 semester: The Bible as Literature.)

The resident advisor for the section of Harper Hall where Cho resided had been forewarned by the previous year's RA that "there were issues" with Cho. She knew about his unwanted advances toward female students and that he was suspected of writing violent song lyrics on the dorm walls that also were posted on his web site. However, she did not encounter a single problem with him.

That fall semester, Cho enrolled in Professor Norris' Advanced Fiction Workshop—a small class of only about 10 students. Cho had taken one of her classes the previous spring, on contemporary fiction, so she knew how little he participated in class. Norris realized that the workshop class would be a problem for Cho because there would be discussions and readings. Cho appeared in class with a ball cap pulled low and making no eye contact. Norris checked with the dean's office to see if it was safe—if Cho was okay—and she asked to have someone intervene on his behalf.

The English Department did not know about Cho's dealings with campus police and the

communications generated from Residence Life about his stalking behavior.

Norris told Cho that he had to come see her if he was going to able to make it through this particular class. She ascertained that Cho had trouble speaking in both English and Korean, and she offered to connect him with the Disability Services Office.

After meeting with Cho, she e-mailed him to reiterate her offers to go with him for counseling or for other services. He did not pursue those offers. His written work was on time and he was on time for class, but he missed the last 2 weeks of class. Cho earned a B+ in Norris's class that semester.

The following semester, spring 2007, Cho began to buy guns and ammunition. His class attendance began to fall off shortly before the assaults. There were no outward signs of his deteriorating mental state. In their last phone call with him the night of April 15, 2007, Mr. Cho and Mrs. Cho had no inkling that anything was the matter. Cho had called per their usual Sunday night arrangement. He appeared his "regular" self. He asked how his parents were, and other standard responses: "No I do not need any money." His parents said, "I love you."

MISSING THE RED FLAGS

The Care Team at Virginia Tech was established as a means of identifying and working with students who have problems. That resource, however, was ineffective in connecting the dots or heeding the red flags that were so apparent with Cho. They failed for various reasons, both as a team and in some cases in the individual offices that make up the core of the team.

Key agencies that should be regular members of such a team are instead second tier, nonpermanent members. One of these, the VTPD, knew that Cho had been cautioned against stalking—twice, that he had threatened suicide, that a magistrate had issued a temporary detention order, and that Cho had spent a night at St. Albans as a result of such detention order. The Care Team did not know the details of all these occurrences.

Residence Life knew through their staff (two resident advisors and their supervisor) that there were multiple reports and concerns expressed over Cho's behavior in the dorm, but this was not brought before the Care Team. The academic component of the university spoke up loudly about a sullen, foreboding male student who refused to talk, frightened classmate and faculty with macabre writings, and refused faculty exhortations to get counseling. However, after Judicial Affairs and the Cook Counseling Center opined that Cho's writings were not actionable threats, the Care Team's one review of Cho resulted in their being satisfied that private tutoring would resolve the problem. No one sought to revisit Cho's progress the following semester or inquire into whether he had come to the attention of other stakeholders on campus.

The Care Team was hampered by overly strict interpretations of federal and state privacy laws (acknowledged as being overly complex), a decentralized corporate university structure, and the absence of someone on the team who was experienced in threat assessment and knew to investigate the situation more broadly, checking for collateral information that would help determine if this individual truly posed a risk or not. (The interpretation of FERPA and HIPAA rules is discussed in a later chapter.)

There are particular behaviors and indicators of dangerous mental instability that threat assessment professionals have documented among murderers. A list of red flags, warning signs and indicators has been compiled by a member of the panel and is included as Appendix M.

KEY FINDINGS – CHO'S COLLEGE YEARS TO APRIL 15, 2007 T

The lack of information sharing among academic, administrative, and public safety entities at Virginia Tech and the students who had raised concerns about Cho contributed to the failure to see the big picture. In the English Depart-

ment alone, many professors encountered similar difficulties with Cho—non- participation in class, limited responses to efforts to personally interact, dark writings, reflector glasses, hat pulled low over face. Although to any one professor these signs might not necessarily raise red flags, the totality of the reports would have and should have raised alarms.

Cho's aberrant behavior of pathological shyness and isolation continued to manifest throughout his college years. He shared very little of his college life with his family, had no friends, and engaged in no activities outside of the home during breaks and summer vacations. While he was an adult, he was a member of the household and receiving parental support, but he did not hold a job to help earn money for college. Unusual by U.S. standards, a high, sometimes exclusive focus on academics is common among parents from eastern cultures.

Cho's roommates and suitemates noted frequent signs of aberrant behavior. Three female residents reported problems with unwanted attention from Cho (instant messages, text messages, Facebook postings, and erase board messages). One of Cho's suitemates combined many of these instances of concern into a report shared with the residence staff. The residence advisors reported these matters to the hall director and the residence life administrator on call. These individuals in turn, communicated by e-mail with the assistant director of Judicial Affairs.

Notwithstanding the system failures and errors in judgment that contributed to Cho's worsening depression, Cho himself was the biggest impediment to stabilizing his mental health. He denied having previously received mental health services when he was evaluated in the fall of 2005, so medical personnel believed that their interaction with him on that occasion was the first time he had showed signs of mental illness. While Cho's emotional and psychological disabilities undoubtedly clouded his ability to evaluate his own situation, he, ultimately, is the primary person responsible for April 16, 2007; to imply otherwise would be wrong.

RECOMMENDATIONS

IV-1 Universities should recognize their responsibility to a young, vulnerable population and promote the sharing of information internally, and with parents, when significant circumstances pertaining to health and safety arise.

IV-2 Institutions of higher learning should review and revise their current policies related to—

a) recognizing and assisting students in distress

b) the student code of conduct, including enforcement

c) judiciary proceedings for students, including enforcement

d) university authority to appropriately intervene when it is believed a distressed student poses a danger to himself or others

IV-3 Universities must have a system that links troubled students to appropriate medical and counseling services either on or off campus, and to balance the individual's rights with the rights of all others for safety.

IV-4 Incidents of aberrant, dangerous, or threatening behavior must be documented and reported immediately to a college's threat assessment group, and must be acted upon in a prompt and effective manner to protect the safety of the campus community.

IV-5 Culturally competent mental health services were provided to Cho at his school and in his community. Adequate resources must be allocated for systems of care in schools and communities that provide culturally competent services for children and adolescents to reduce mental-illness-related risk as occurred within this community.

IV-6 Policies and procedures should be implemented to require professors

encountering aberrant, dangerous, or threatening behavior from a student to report them to the dean. Guidelines should be established to address when such reports should be communicated by the dean to a threat assessment group, and to the school's counseling center.

IV-7 Reporting requirements for aberrant, dangerous, or threatening behavior and incidents for resident hall staff must be clearly established and reviewed during annual training.

IV-8 Repeated incidents of aberrant, dangerous, or threatening behavior must be reported by Judicial Affairs to the threat assessment group. The group must formulate a plan to address the behavior that will both protect other students and provide the needed support for the troubled student.

IV-9 Repeated incidents of aberrant, dangerous, or threatening behavior should be reported to the counseling center and reported to parents. The troubled student should be required to participate in counseling as a condition of continued residence in campus housing and enrollment in classes.

IV-10 The law enforcement agency at colleges should report all incidents of an issuance of temporary detention orders for students (and staff) to Judicial Affairs, the threat assessment team, the counseling center, and parents. All parties should be educated about the public safety exceptions to the privacy laws which permit such reporting.

IV-11 The college counseling center should report all students who are in treatment pursuant to a court order to the threat assessment team. A policy should be implemented to address what information can be shared with family and roommates pursuant to the public safety exceptions to the privacy laws.

IV-12 The state should study what level of community outpatient service capacity will be required to meet the needs of the commonwealth and the related costs in order to adequately and appropriately respond to both involuntary court-ordered and voluntary referrals for those services. Once this information is available it is recommended that outpatient treatments services be expanded statewide.

The panel's report deals with facts. Sometimes, however, police investigation requires educated guesses and speculation—such as in instances where a "profile" of an unknown killer is generated by FBI profilers, who are specially trained in this area. Set forth in Appendix N is such a work, written by panel member Dr. Roger Depue, who is, among many other qualifications, a former FBI profiler. While no member of the panel can definitively ascertain what was in Cho's mind, this profile offers one theory.

Part B – Virginia Mental Health Law Issues

The Commonwealth of Virginia Commission on Mental Health Law Reform was appointed in October 2006, by Virginia Chief Justice Leroy R. Hassell, Sr. The 26-member commission, chaired by Professor Richard J. Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia, is charged to "conduct a comprehensive examination of Virginia's mental health laws and services" and to "study ways to use the law more effectively to serve the needs of people with mental illness, while respecting the interests of their families and communities."

The commission has held four meetings with another scheduled for November 2007 and is working through five task forces with more than 200 participants. The Task Force on Civil Commitment is addressing criteria for inpatient and outpatient commitment, transportation, and the emergency evaluation process, procedures for

hearings, training, and compensation for participants in the process, and oversight.

The Task Force on Civil Commitment will submit its final report to the commission in November 2007. The commission intends to prepare a preliminary report during the winter and to submit a final report by the fall of 2008 for consideration by the 2009 General Assembly.

The discussion that follows constitutes an abridged effort, due to constraints of time and manpower, to address some of the issues that will be dealt with by the commission in a far more comprehensive manner. Many of the panel's recommendations are framed in general terms with the expectation that the commission will formulate specific proposals.

Throughout the panel's work, there was close collaboration with Professor Bonnie and James Stewart, the Inspector General for the Department of Mental Health and Mental Retardation and Substance Abuse Services. The inspector general released a report in June 2007 detailing his findings concerning Cho's interaction with mental health services in Virginia.

TIME CONSTRAINTS FOR EVALUATION AND HEARING

Va. Code 37.2-808 establishes the procedures for involuntary temporary detention of persons who are mentally ill, present an imminent danger to self or others, and are in need of hospitalization but unwilling or unable to volunteer for treatment. Subsection H provides that no person shall remain in custody for longer than 4 hours without a temporary detention order issued by a magistrate. In Cho's case, the New River Valley CSB was able to provide a pre-screener in a timely manner, and she was able to conduct the screening and locate an available bed in order to present the matter to the magistrate within the required 4-hour period.

However, mental health service providers and special justices interviewed for this report set forth numerous arguments as to why this period should be lengthened to either 6 hours or to permit one renewal of the 4-hour period for good cause. The concerns raised included that it is often difficult to promptly secure qualified personnel to perform the prescreening evaluation given staff resources and required travel time, particularly in rural jurisdictions. It is often even more difficult to locate the available bed required for a temporary detention order (TDO) to issue. Four hours do not allow sufficient time to gather meaningful collateral information from family, friends, or other health care providers nor to secure proper evaluations for medical clearance. Some noted, however, that an extension of the 4-hour period may require police departments to spend more time with a person in emergency custody in those locales where hospital security are unable to assume responsibility.

The American College of Emergency Physicians (ACEP) has recommended that emergency physicians trained in psychiatric evaluation be given more authority in the involuntary hold process. Since emergency departments are 24-hour facilities, resources are already in place. Because the CSB serves an independent "gatekeeper" role under the Virginia TDO process, emergency physicians and CSB staff are generally expected to work collaboratively in determining whether a TDO is needed for those patients screened in emergency departments. However, where CSB pre-screeners are not immediately available, properly trained emergency physicians can effectively screen patients under an emergency custody order and communicate with the magistrate to obtain the TDO when needed. If such a gate keeping responsibility were to be conferred on emergency physicians, further questions would have to be addressed regarding the respective roles of the emergency physicians and the CSB staff in exploring alternatives to hospitalization and in participating in the commitment hearing.

Under current Virginia law, the duration of temporary detention may not exceed 48 hours prior to a hearing (or the next day that is not a Saturday, Sunday, or legal holiday). The mental health service providers in Cho's case were able to comply with the 48-hour requirement; however, the information available to the

special justice was extremely limited. There was no history regarding prior treatment; there were no lab or toxicology reports, nor the report regarding access to a firearm. At the hearing, there were no witnesses present such as family, roommate/suitemates, the CSB pre-screener, the independent evaluator, or the treating psychiatrist.

Mental health professionals interviewed reported that 48 hours is one of the shortest detention periods in the nation and recommended that it be lengthened. Reasons cited for expanding this period included the need to contact family or friends and to explore the person's prior history. Also cited was the need for a more comprehensive independent evaluation and the difficulty in securing a complete report of the treating psychiatrist in time for the hearing. It was suggested that a psychiatric "workup" as well as a toxicology screen be available to the independent examiner. A further concern was that often psychiatric inpatient bed space is not available within the 48 hours. As a financial consideration, it was argued that a longer period would allow patients an opportunity to stabilize or recognize the need for voluntary treatment, thereby reducing the number of commitment hearings and the costs associated with special justices and appointed counsel.

STANDARD FOR INVOLUNTARY COMMITMENT

The judge or special justice ordering commitment must find by clear and convincing evidence that the person presents (1) an imminent danger to himself or others or is substantially unable to care for himself, and (2) less restrictive alternatives to involuntary inpatient treatment have been investigated and are deemed unsuitable. Cho was found to be an imminent danger to himself by the pre-screener who also found that he was "unable to come up with a safety plan to adequately ensure safety." He was unwilling to contact his parents to pick him up. However, Cho was found *not* to be an imminent danger to self or others by both the independent examiner and the treating psychiatrist at St. Albans, and accordingly neither recommended involuntary admission. At the commitment hearing, the special justice did find Cho to be an imminent danger to himself; however, he agreed with the independent examiner and treating psychiatrist that a less restrictive alternative to involuntary admission, outpatient treatment, was suitable. Perhaps Cho presented himself differently at various stages of the commitment process or perhaps the professionals had differing evaluations of someone who did not speak much or perhaps they had differing interpretations of the standard set forth in the Virginia Code.

Mental health professionals advised the panel that the standard "imminent danger to self or others" is not clearly understood and is subject to differing interpretations. They recommend that the criteria for commitment be revised to achieve a more consistent application. Service providers and special justices suggest that the "imminent danger" criterion should be replaced by language requiring "a substantial likelihood" or "significant risk" that the person will cause serious injury to himself or others "in the near future." A few disagreed on the basis that personal rights of liberty should be paramount, and that changing the standard would lower the threshold for admission. Proponents for modifying the criteria respond that Virginia's commitment standard is one of the most restrictive of all the states. They contend that the threshold finding prevents intervention in cases of severe illness accompanied by substantial impairment of cognition, emotional stability, or self-control.

PSYCHIATRIC INFORMATION

Many of those interviewed expressed serious concerns regarding the paucity of psychiatric information available to the independent evaluator and judge/special justice. As noted above, the independent evaluator for Cho had only the report from the CSB pre-screener and no collateral information or medical records. The independent evaluator plays a key role in the commitment process in many jurisdictions. In Cho's case, notwithstanding the finding from the independent evaluator that Cho did not pose an imminent threat, the special justice,

nevertheless convened the hearing and actually made a finding that differed from that of the independent evaluator. He did, however, agree with the independent evaluator that inpatient treatment was not required. The panel was advised that in many jurisdictions, absent a finding by the independent evaluator that an individual poses an imminent danger or is substantially unable to care for himself, many special justices will decline to hold a hearing.

It is unclear under existing law whether the independent evaluator is intended to serve as a gate keeper. If the opinion of the independent evaluator is to be given great weight, then it is critical that sufficient psychiatric information be available upon which an informed judgment may be made. Background information including records from the current hospitalization must be assembled for review. The Cho case calls attention to the need to assure that the independent evaluator has both sufficient time and information to conduct an adequate evaluation.

At Cho's hearing, the only documents available to the special justice were the Uniform Pre-Admission Screening Form, a partially completed Proceedings for Certification form recording the findings of the independent evaluator and a physician's examination form containing the findings of the treating psychiatrist. No prior patient history was presented; no toxicology, lab results, or physical evaluation from the treating psychiatrist were available. The admitting form indicating that Cho had access to a firearm was not presented.

Panel members have been advised by mental health providers and special justices from other locales in Virginia that it is not unusual for the evidence presented at commitment hearings to be minimal. Due to the time constraints and limitations of resource personnel, the information available to the judge/special justice is often very limited. Witnesses cannot be located quickly and hospital records have often not been transcribed. Additionally, conflicting interpretations of the constraints of the Health Insurance Portability and Accountability Act (HIPAA) and Virginia Code 32.1-127.1:03 Health Records Privacy (VaHRP) often make it difficult to acquire background medical/psychiatric information on a patient previously treated elsewhere. Legal experts from a research advisory group for the Commission on Mental Health Law Reform participated in the development of a questionnaire for judges and special justices to complete following civil commitment hearings in the month of May 2007. More than 1400 questionnaires were returned. They reflected that approximately 60 percent of the May hearings lasted no more than 15 minutes and only 4 percent required more than 30 minutes.

Cho was the only person to testify at his commitment hearing, and he was not very communicative. The pre-screener was not present nor was any representative from the CSB. The independent evaluator was not present. The officer who detained Cho was not present. Cho's roommate, suitemates, and Cho's family were all absent. This apparently is not an unusual scenario for commitment hearings in Virginia. Often the pre-screener is off duty by the time of the hearing. CSBs with limited staff frequently do not send a substitute. (The commission's survey reflected that the CSB representatives attended only half of the hearings held in May, 2007). Independent evaluators, paid $75 per commitment evaluation, often feel compelled to return to their private practice rather than waiting for hearings that may be held hours after the evaluation is complete. (The responses to the questionnaires indicated that the independent evaluators were present at approximately two-thirds of Mays hearings.) Due to time constraints and concerns regarding HIPAA and VaHRP restrictions, friends and family are often not notified.

HIPAA and VaHRP generally require that no health care entity disclose an individual's health records or information. However, permitted exceptions are information necessary for the care of a patient and information concerning a patient who may present a serious threat to public health or safety. Therefore, a treating physician at the facility where a patient is detained should be granted access to all prior psychiatric history. These exceptions, however

do not clearly permit these records be shared with the judge or special justice at the commitment hearing. Although a person may consent to the release of information to any person or entity, detained individuals are often unable or disinclined to do so.

Because interpretation of HIPAA and FERPA were key in stopping adequate exchange of information concerning Cho, the panel requested that its legal council research the interpretation and exceptions under these laws, which is presented in the next chapter.

INVOLUNTARY OUTPATIENT ORDERS

In conducting the investigation, the panel encountered many questions concerning involuntary outpatient orders. What specificity should be required of outpatient orders? To whom should notice of outpatient orders be given? How should compliance with outpatient orders be monitored? What procedures should be available to address noncompliance and what resources are needed?

The special justice ordered that Cho receive outpatient treatment; however, the order provided no information regarding the nature of the treatment other than to state "to follow all recommended treatments." The order did not specify who was to provide the outpatient treatment or who was to monitor the treatment.

There was considerable support among those interviewed by panel members for greater guidance in the Virginia Code regarding outpatient treatment orders. Some felt that the order should track recommendations from the treating physician as to the frequency and duration of treatment and whether medication was required. Others observed that often physician's evaluations and orders were not available and the special justice/substitute judge did not have the expertise to order specific treatment. However, all agreed that more specificity in outpatient treatment orders is essential.

New River Valley CSB did not have a representative at Cho's hearing due to financial constraints. Va. Code 37.2-817(C) currently requires the CSB to recommend a specific course for involuntary outpatient treatment and to monitor compliance. However, the Code does not specify how or by whom the CSB will be notified that outpatient treatment has been ordered if a representative is not present at the hearing. There exists a disagreement as to whether the CSB was advised of the entry of the outpatient order in Cho's case. The clinical support representative for St. Albans advised that he always calls the CSB following commitment hearings to report the results. The CSB reports that they have no record of having been notified. If the CSB is represented at the hearing, there can be no reason for confusion. However, if Virginia Code is not amended to require the presence in person or telephonically, it must be amended to designate who has responsibility for certifying a copy of the outpatient order to the CSB. There should also be clear guidance provided in the Virginia Code as to who has responsibility for notification if a private mental health practitioner is to provide the mandated outpatient treatment.

No notice of the hearing or the order issued by the special justice was given to Cho's family, his roommate/suitemates, the VTPD, or the Virginia Tech administration. The Code of Virginia authorizes no such notice. The recordings of the hearing must be kept confidential pursuant to Va. Code 37.2-818(A). The records, reports and court documents pertaining to the hearing are kept confidential if so requested by the subject of the hearing under 37.2-818(B) and are not subject to the Virginia Freedom of Information Act. HIPAA and VaHRP restrictions may further limit dissemination of certain information as no person to whom health records are disclosed may redisclose beyond the purpose for which disclosure was made. Concerns were raised by many interviewees and speakers at panel hearings that family members, those residing with the subject of a commitment hearing, the police department and school officials should all be notified of the hearing and its outcome in the interest of public safety.

In Cho's case, there are conflicting reports regarding the issue of notice to the treatment provider, Cook Counseling Center. An appointment

had been scheduled by Cho with the assistance of the clinical support representative for St. Albans. The representative reports that he faxed a copy of the discharge summary to Cook. Cook, however, contends that they did not receive any written documentation until January, and even then it was the physical examination which indicated that Cho would be treated by the St. Alban's psychiatrist. Following Cho's in-person triage appointment on December 14, the Cook Counseling Center left it to Cho's discretion whether to return for follow up treatment. When he did not, it was not reported to the special justice, St. Alban's, or the CSB. The Virginia Code imposes no legal obligation for Cook Counseling Center to do so, and Cook counselors question whether they have the right to do so given the restrictions of HIPAA and VaHRP.

Furthermore, there exists the question of whether Cho was noncompliant given the general language of the involuntary treatment order; and if Cho were considered noncompliant, how was that to be addressed. There is no contempt provision in the Virginia Code for those noncompliant with involuntary outpatient orders. There is no guidance as to the nature of the hearing to be held for noncompliance; nor is there a basis for compensating the special justice/substitute judge or attorney for followup proceedings. Many questions are raised. If a form is created to report noncompliance, can a treatment provider file the report without violating HIPAA and VaHRP? If the noncompliance report is filed, how does the special justice secure the presence of the individual for a followup hearing? If the noncompliant individual does not pose an imminent danger to himself or others at the time of the followup hearing, an emergency custody order cannot be issued; nor can the special justice order involuntary inpatient treatment. Should there be a Code provision allowing for a short period of inpatient treatment for those not compliant with the outpatient order yet not an "imminent danger" at the time returned for noncompliance? Will commitment for noncompliance pose yet another burden on the already overcrowded inpatient facilities?

On June 22, 2007, the Commission on Mental Health Law Reform released the final report of its study of the current commitment process. This study, undertaken for the commission by Dr. Elizabeth McGarvey of the University of Virginia School of Medicine, involved intensive interviews with 64 professional participants in the process, 60 family members of persons with serious mental illness, and 86 people who have had the experience of being committed. According to Dr. McGarvey's report, professional participants and family stakeholders are uniformly frustrated by almost every aspect of the civil commitment process in Virginia. Among the most common complaints were a shortage of beds in willing detention facilities, insufficient time for adequate evaluation, the high cost and inefficiency of transporting people for evaluation, inadequate compensation for professional participants in the process, inadequate reimbursement for hospitals, inconsistent interpretation of the statute by different judges, and lack of central direction and oversight.

CERTIFICATION OF ORDERS TO THE CENTRAL CRIMINAL RECORDS EXCHANGE

Va. Code 37.2-819 requires the clerk to certify, on a form provided, any order for involuntary admission to the Central Criminal Records Exchange. The section does not specify who bears responsibility for completion of the form. The failure of Va. Code 37.2-819 to specify responsibility for preparation of the order furnished by the Central Criminal Records Exchange was noted to be a problem. It is reported that in some jurisdictions, if the clerk is not furnished the completed form, no form is forwarded to the exchange. There is lack of consistency throughout the Commonwealth regarding who prepares the forms. In some jurisdictions, the forms are completed by the special justice/substitute judge, in others by the clerk of court, and reportedly in others, the forms are often not completed at all.

Of further concern was the issue of under what circumstances the forms are to be completed. Mental health and legal professionals

interviewed by panel members felt that there was no reasonable distinction to be drawn between persons ordered for involuntary inpatient treatment and those ordered for involuntary out-patient treatment when a finding has been made that the individual poses an imminent danger to self or others. If firearms restrictions apply, they should be based upon the fact that an individual poses a danger, not on the basis of the type of treatment ordered; therefore, both involuntary inpatient and involuntary outpatient treatment orders should be certified. While the governor has addressed this matter by executive order, it was felt that legislation should be enacted embodying the certification requirement. Mental health and legal experts also raised the question of whether persons electing voluntary admission upon being advised of their right to do so during the commitment hearing should also be reported. (The commission's survey indicated that 30 percent of the commitment hearings in May resulted in voluntary admission.)

It was also noted with concern by the mental health and legal experts interviewed that the reporting requirement does not apply to orders for juveniles found to pose an imminent danger, regardless of whether inpatient or outpatient treatment was ordered. They further expressed concern regarding the absence of any provision in the Virginia Code requiring the clerk to certify orders pertaining to persons found not guilty by reason of insanity.

KEY FINDINGS

Statutory time constraints for temporary detention and involuntary commitment hearings significantly impede the collection of vital psychiatric information required for risk assessment.

The Virginia standard for involuntary commitment is one of the most restrictive in the nation and is not uniformly applied.

The fact that a CSB representative did not attend the commitment hearing and the failure to certify a copy of the outpatient commitment order to the CSB resulted in an absence of oversight for Cho's outpatient treatment.

The lack of a requirement in the Virginia Code to certify outpatient commitment orders to the CCRE resulted in Cho's name not being entered in the database, which could have prevented his purchase of firearms.

There was a lack of doctor-to-clinician contact between St. Albans Hospital and the Cook Counseling Center.

In the wake of the Virginia Tech tragedy, much of the discussion regarding mental health services has focused on the commitment process. However, the mental health system has major gaps in its entirety starting from the lack of short-term crisis stabilization units to the outpatient services and the highly important case management function, which strings together the entire care for an individual to ensure success. These gaps prevent individuals from getting the psychiatric help when they are getting ill, during the need for acute stabilization, and when they need therapy and medication management during recovery.

RECOMMENDATIONS

IV-13 Va. Code 37.2-808 (H) and (I) and 37.2-814 (A) should be amended to extend the time periods for temporary detention to permit more thorough mental health evaluations.

IV-14 Va. Code 37.2-809 should be amended to authorize magistrates to issue temporary detention orders based upon evaluations conducted by emergency physicians trained to perform emergency psychiatric evaluations.

IV-15 The criteria for involuntary commitment in Va. Code 37.2-817(B) should be modified in order to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness.

IV-16 The number and capacity of secure crisis stabilization units should be expanded where needed in Virginia to ensure that individuals who are subject to a temporary detention order do not need to wait for an available bed. An increase in capacity also will address the use of inpatient beds for moderately to severely ill patients that need longer periods of stabilization.

IV-17 The role and responsibilities of the independent evaluator in the commitment process should be clarified and steps taken to assure that the necessary reports and collateral information are assembled before the independent evaluator conducts the evaluation.

IV-18 The following documents should be presented at the commitment hearing:

- ***The complete evaluation of the treating physician, including collateral information.***
- ***Reports of any lab and toxicology tests conducted.***
- ***Reports of prior psychiatric history.***
- ***All admission forms and nurse's notes.***

IV-19 The Virginia Code should be amended to require the presence of the prescreener or other CSB representative at all commitment hearings and to provide adequate resources to facilitate CSB compliance.

IV-20 The independent evaluator, if not present in person, and treating physician should be available where possible if needed for questioning during the hearing.

IV-21 The Virginia Health Records Privacy statute should be amended to provide a safe harbor provision which would protect health entities and providers from liability or loss of funding when they disclose information in connection with evaluations and commitment hearings conducted under Virginia Code 37.2-814 et seq.

IV-22 Virginia Health Records Privacy and Va. Code 37.2-814 et seq. should be amended to ensure that all entities involved with treatment have full authority to share records with each other and all persons involved in the involuntary commitment process while providing the legal safeguards needed to prevent unwarranted breaches of confidentiality.

IV-23 Virginia Code 37.2-817(C) should be amended to clarify—

- ***the need for specificity in involuntary outpatient orders.***
- ***the appropriate recipients of certified copies of orders.***
- ***the party responsible for certifying copies of orders.***
- ***the party responsible for reporting noncompliance with outpatient orders and to whom noncompliance is reported.***
- ***the mechanism for returning the noncompliant person to court.***
- ***the sanction(s) to be imposed on the noncompliant person who does not pose an imminent danger to himself or others.***
- ***the respective responsibilities of the detaining facility, the CSB, and the outpatient treatment provider in assuring effective implementation of involuntary outpatient treatment orders.***

IV-24 The Virginia Health Records Privacy statute should be clarified to expressly authorize treatment providers to report noncompliance with involuntary outpatient orders.

IV-25 Virginia Code 37.2-819 should be amended to clarify that the clerk shall immediately upon completion of a commitment hearing complete and certify to the Central Criminal Records Exchange, a copy of any order for involuntary admission or involuntary outpatient treatment.

IV-26 A comprehensive review of the Virginia Code should be undertaken to determine whether there exist additional situations where court orders containing mental health findings should be certified to the Central Criminal Records Exchange.

ADDITIONS AND CORRECTIONS

Ruling on Cho's Poem: p. 43, Clarification – To be clear, it was the content of the **poem** written by Cho to which Director of Judicial Affairs Frances Keene was referring in the second paragraph, second column, which might have been confusing because the immediately preceding issue discussed in the paragraph is Cho's secret photos in the classroom.

Name and Title: p. 44, Correction – Rohsaan Settle should have been identified as a member of the Residence Life staff and not the Assistant Director of Judicial Affairs. The reference to Settle as "she" also is incorrect.

E-mail to Rohsaan Settle: p. 44, Addition – The email Settle received on December 6 concerning Cho's behavior was sent by an RA, Lisa Virga. She advised Settle of Cho's "odd behavior" and described Cho's "stalking" of a student, Christina Lillizu, who lived in Cochrane residence hall on the other side of the third floor where Cho lived. Cho had a class with Lillizu. He harassed her online, talked to her on IM, and went to her room twice, once in disguise. Lillizu reportedly did not confront Cho because she was afraid to but did contact VTPD after Cho appeared at her door in disguise. (The exact date and time of the VTPD contact are not known because there is no incident report at VTPD on that contact.) Ms. Virga also explained to Settle that Cho had two knives in the dorm room, though she did not specify the size of the knives. Mr. Settle responded to the RA that they should "chat" about the knives. There are no records indicating that Mr. Settle followed up with VTPD to report the possession of knives – which, if of a certain size, was a violation of the Code of Conduct - and the pattern of Cho's aberrant behavior. Mr. Settle has said he is not sure if he responded to the information in Virga's email but he thought VTPD was handling it.

Nature of Complaint: p. 45, Addition – The text says "…on Sunday, November 27, the police, following a complaint from a female student who lived on the fourth floor of West Ambler Johnston, came to Cho's room to talk to him." To elaborate, it was about 11:30 p.m. when a VTPD officer responded to 4021 West Ambler Johnston due to a harassment complaint from student Jennifer Nelson. She reported that she had received multiple IMs from someone who gave a false address and false email address. He also had called her. Nelson had no idea who he was, though he said they went to the same high school; she had identified him through Facebook. He had just come to her room, calling himself "The Question Mark Kid." Nelson and her roommate told him to leave and said they were calling police.

The officer investigated the moniker "question mark" on Facebook and confirmed Cho's identification and address after speaking with one of the individuals listed as Cho's friend. The officer immediately went to Cho's dorm room, read him his Miranda rights, and questioned him. The officer told Cho not to have any contact with Nelson by any means. Cho also was told there could be a judicial referral filed, but no criminal charges were being placed at that time.

The officer then returned to West Ambler Johnston to speak with Nelson. Nelson read Cho's statement, said she did not want to press criminal charges but would be comfortable testifying if there were a judicial hearing. The officer advised Nelson he would file a judicial referral, which he did. According to Virginia Tech policy, *either* a law enforcement officer *or* a victim can make a judicial referral. However, when Judicial Affairs followed up with Nelson they told her that in addition to the VTPD referral, she, too, would have to make a referral for them to pursue the matter. She declined.

Cho's CCC File: p. 46, Corrections and Clarification – There are several corrections to the text in the second paragraph of the left column. First the written documentation of Dr. Betzel's December 12 triage of Cho is no longer missing as it is part of the file found in Dr. Miller's home, as discussed previously. Second, the consultation between Dr. Betzel and Dr. Roy is misplaced in the chapter and should appear on page 43 as it relates to the activities surrounding Cho's removal from Dr. Giovanni's class. Moreover, the last sentence of that paragraph should be deleted and replaced with this text:

> Dr. Roy's consultation with Dr. Betzel occurred around October 18, 2005 during the course of handling and following up on Dr. Giovanni's alarm about Cho's writings and behavior in class. This consultation predated Cho's triage appointments at CCC. There should have been a Triage Report on this consultation somewhere in the CCC records, but it would *not* typically have been part of a file on Cho unless it was connected to him after his visit to CCC and his subsequent case file. There were no formal procedures for what to do with these forms after they were reviewed by the CCC Director and returned to the front desk.

According to the Virginia Inspector General's report #179-09, *Investigation-Records, Virginia Tech Cook Counseling Center*, p. 9, issued November 9, 2009, the practice at CCC in the fall of 2005 was as follows:

> "CCC counselors periodically had contact with faculty, university staff and parents who sought consultation regarding students about whom they were concerned. This occurred both for students who were being served by the Center and for students who had had no contact with the Center. It was expected that each consultation was to be documented on a separate Triage Form."

The Triage Forms were then to be placed in Dr. Miller's inbox for review and later filing in the front office "where all Triage Forms on students whose cases have not yet been opened are filed." To the extent that Triage Forms were completed for the consultations between faculty and the CCC and between administrators and the CCC concerning Cho they would not have been saved in a file with Cho's name because he was not an established patient there at that time. (Most of these communications were e-mails, not Triage Forms). Moreover, when a student is not identified during a consultation (as was the case with at least one about Cho) the Triage Form would likely not be linked to the student in question if he or she were to seek CCC services later and have a file started at that time. It was not a requirement to name the individual in question during a consultation.

Female Student Complaints About Cho: p. 46, Addition – More details are available about the call to VTPD on December 12, 2005. The complaint was from Margaret Bowman, 306 East Campbell residence hall, and regarded harassment by Cho. Bowman was upset over a series of unwanted communications over several days. Cho had sent her an IM on December 9. Then, on December 11 in the evening, she discovered an excerpt from Shakespeare written on the whiteboard outside her door. Returning from an exam the following morning, she found that a continuation of the quotation from Shakespeare had been added. She believed Cho was responsible because mutual friends told her that when they mentioned the situation to Cho he commented that "Shakespeare wrote it."

One of the responding officers went to Cho's room and left a message with Cho's roommate for Cho to contact the officers; they also sent an email to Cho requesting the same.

Discharge Summary to CCC: pp. 48–49, Correction – The last sentence of page 48 states that Cook Counseling Center has "no record of having received any hospital records until January 2006," which is what had been reported to the Review Panel. It is now known that on December 14, 2005 at 2:25 p.m., 35 minutes before Cho was seen at CCC, the CCC received a fax from Diane Turner at Carilion Health System in Radford. The fax included a discharge summary by Dr. Migliani which was transcribed on 12/14/05 at 11:57. The fax also included the New River Valley Community Services Uniform Pre-admission Screening Form of 12/13/05 completed by Kathy Godbey. Full hospital records were mailed, but not received (or marked as received) until 1/06.

Cho Writings and Professor Hicok's Class: p. 50, Corrections and Clarification – The Review Panel's concern over not receiving from Professor Hicok a copy of Cho's writing and of that writing not being mentioned by Professor Hicok was largely unwarranted. Professor Hicok had turned over some of Cho's writings in his class to an FBI agent acting on behalf of the Virginia State Police just two days after the April 16 shootings. Hicok thought the VSP would share the documents with the Review Panel, but they did not, apparently because they considered Cho's writings part of their investigation file.

Professor Hicok told the Review Panel that Cho's responses to writings by other students (not Cho's own writing as stated in the Report) were surprisingly cogent, but that Cho was not a good creative writer. Cho was open to suggestions and made some edits in response to suggestions. Professor Hicok noted that Cho's writing was "not unique in terms of subject matter," and though "remarkable for violence," he added, "I have seen worse."

Lack of Further Police Contact – Virginia Tech police noted that Cho had no further contact with law enforcement after they took him for evaluation on Dec 13-14 2005 until he received a speeding ticket on March 31, 2007, and they were not informed about his additional problems.

More Lack of Attention to Red Flags: p. 53, Addition – The finding that there was lack of adequate attention by Virginia Tech to the red flags raised by Cho's actions is reinforced by further examination of communications among faculty and Virginia Tech staff. The Review Panel faulted Virginia Tech for not connecting the dots. Since then, more unconnected "dots" have come to light. Members of the Virginia Tech administration and campus police failed to adequately heed warnings and take the initiative to investigate more fully a long list of frightening writings and aberrant behaviors leading up to the shootings, especially those reported by the resident advisors and English Department faculty. Examples are given in the various addenda here, such as the discussion of the email to Settle above.

OTHER COMMENTS

1. **File on Cho at the CCC and the Relative Importance of Counseling for Cho:** Some of the comments that related to the CCC's file on Cho, placed a heavy emphasis on the importance of that file and what impact counseling at CCC would have had on Cho. One individual stated that those records "were the linchpin that could have connected the dots." Another comment was that the Review Panel saw only some of Cho's records, but not crucial records.

Response: The papers in the file on Cho provided very little information that the Review Panel did not already have. The Review Panel sought and received a huge amount of crucial records, both academic and medical, from Cho's middle school, high school, and Virginia Tech years. The Review Panel also interviewed Cho's high school counselor, doctors and therapists in Northern Virginia, plus professors and health/mental health practitioners at the CCC and at the CSB. The records from practitioners who treated Cho **before** he attended Virginia Tech are far more informative and relevant than the intake forms in Cho's file from CCC. We also had his court records and met with Special Justice Paul M. Barnett who conducted Cho's commitment hearing. Additional factors to consider with regard to Cho and counseling include the following:

- Cho would not talk much. He was a poor candidate for traditional talk therapy because he would not communicate, did not want to be in therapy, and was not legally required to go for counseling. For therapy to have any effect and value to a patient the person must truly want to participate in the sessions and work with the therapist. Cho contacted CCC because he was getting into trouble with Virginia Tech police and then because it was required prior to his discharge from St. Albans. Since he lied about previous mental health problems, (including his ideas of suicide and homicide, prior years in art therapy, and medication for depression), to all medical personnel, evaluators, and court officials who dealt with him, he likely would have continued denying problems, much like he denied being serious about his suicide threat.
- Cho's parents initiated therapy for Cho the summer before he started 7th grade because they were concerned about his social isolation and unwillingness to discuss his thoughts or feelings. The only therapy that could be used with Cho was art therapy, typically used for very young children, because it did not require him to talk. His art therapist told the Review Panel that through clay, drawings, and other media, she was able to diagnose his extreme loneliness and isolation. Some limited progress was made in connecting with him and getting him to make eye contact, though he remained unwilling to respond verbally in a significant way.
- There is an extremely relevant note in the psychological evaluation of Cho contained in Cho's high school files. The psychologist wrote: "The quality of any diagnosis made or care delivered will depend, to a large extent, on the quality of information exchanged in **both** (emphasis added) directions…. Psychological therapy in the form of counseling is likely to be difficult and of limited effectiveness given Seung-Hui's extreme reticence and apparent anxiety. There are reports that Seung-Hui resents his participation in therapy and attends only grudgingly."

2. **Availability of Home Town Doctor:** One commenter asked, "Why did the panel not check into why Virginia Tech records indicate that there was a "home town" doctor or counselor that Cho could see when he was home? What written document led the panel to make their decision that Cho had a "home town" doctor or counselor?

   ***Response*:** During Cho's interactions with medical personnel on December 13-14, he had nodded a "yes" to having doctors available at home, and that was noted on the record. Additionally, the Review Panel interviewed various health and mental health providers that had treated Cho in Northern Virginia.

3. **Dr. Roy's Warning to Cho Regarding Referral to Judicial Affairs:** A commenter claimed that Dr. Roy and others failed to address or discuss that Cho was guilty of violating the Code of Student Conduct and that Dr. Roy did not tell Cho that he had violated the CSC and that similar behavior in the future would be referred to Judicial Affairs.

   Response: Chapter IV, page 43, discusses the Code of Student Conduct, that Dr. Roy had asked Dean Brown about it, and that he had responded that Cho's cell phone picture-taking would "clearly" fall under "disorderly conduct, if adjudicated." Brown also spoke with Frances Keene who agreed with Dr. Roy's plan to meet with Cho and propose individual work with her and Professor Fred D'Aguiar. Keene communicated to Roy and Brown she was available if Cho had questions. Moreover, detailed notes of the meeting with Cho, Dr. Roy, and Cheryl Ruggiero (serving as assistant chair in the English Department at the time) document the following exchange:

   L: [Lucinda Roy] asks about Cho's taking photos of the students in the class

   Cho: says it is "just a hobby," that he takes pictures of "trees, sky…"

   L: explains that taking unauthorized photographs, without permission from the subjects, and especially publishing them on a website, is something the University is taking very seriously, and that is could be something that could get a student into trouble."…asks if Seung understands

   Cho: "Yeah"

4. **Dr. Roy and Attempt to Get Cho to Seek Counseling:** A commenter noted that the Report states that Dr. Roy tells others she will try to get Cho to go to counseling, "but she does not mention it in her last email to Cho, or future communication."

   Response: Dr. Roy urged Cho to get counseling multiple times and personally called CCC to see if Cho could be required to get counseling. The counselor informed Dr. Roy of CCC's then-existing rules that CCC only saw students who voluntarily sought counseling. Dr. Roy pleaded with the counselor to come to Shanks Hall to meet Cho, and the counselor declined due to then-existing CCC policy to only counsel students at the CCC. Dr. Roy writes in *No Right to Remain Silent* (Chapter Two) about how often she brought up the subject of counseling and Cho's response was always noncommittal. She even offered to go with him to CCC, and she recommended a particular counselor by name. Page 46 of the Report discusses Dr. Betzel's recollection of Dr. Roy contacting her regarding a student Dr. Betzel believes was Cho, his writing, and Dr. Roy's plans to meet with Cho individually.

5. **Notification to VTPD Regarding Cho's Writings:** There was an objection that the Report did not discuss that Dr. Roy and Mary Ann Lewis failed to notify VTPD of the content of Cho's writings, and that Cho's writings were not forwarded to a counselor.

   ***Response*:** The Report discusses that Cho's "poem" written in Dr. Giovanni's class was sent to the CCC for review and the CCC responded that Cho's wirings, while disturbing, did not seem threatening since he did not specify a target. He had not committed a crime therefore contacting police and naming Cho would not have been appropriate. VTPD were informed that security might be needed due to a concern in Dr. Giovanni's classroom; however, since Cho did not return to that class, the security was cancelled.

6. **Criminal Charges Against Cho**: The comment was that the report fails to reveal if criminal charges were filed by Margaret Bowman regarding Cho's message on her white board and Facebook/emails.

   Response: Page 46 of the Report states: "She [Bowman] did not file criminal charges."

7. **Discrepancies Between the Inspector General's Report, Investigation of April 16, 2007 Critical Incident at Virginia Tech and the Panel Report**: A commenter charged that information was intentionally omitted and misleading.

   Response: There were two minor discrepancies between the two reports, both of which covered an enormous amount of detailed information. The two discrepancies are:

   - IG's report notes that Cho harassed Margaret Bowman on 3 occasions. The Review Panel Report documents one. The Review Panel did not have the VTPD incident reports which now are available, and which show the three dates. This addendum reflects the additional incidents.
   - IG's report notes that the father of Cho's suitemate called VTPD at 3:42 concerning Cho's suicide threat. Commenter says the Review Panel Report is incorrect and that Cho's suitemate [Andy Koch] did not call VTPD. However, a VTPD Incident/ Investigation Report dated 12/13/05 states: "On 12-13-05 at approximately 1909 hours, I, Officer Lucas received a phone call from [suitemate]Andy Koch… Andy advised that Mr. Seung Hui Cho had sent him an instant message earlier today saying that he was thinking about killing himself." Andy Koch's father also may have contacted police independently.

8. **Interviews of RAs:** Commenter states the Review Panel only interviewed one RA, Melissa Troutman and that other RA's should have been interviewed.

   Response: Appendix B, page 9, of the original Report indicates the Review Panel interviewed three RAs: Troutman, Chandler Douglas (the RA during Cho's senior year) and Austin Moron.

9. **Events of December 12, 2005 on:** Commenter states that the Report lacks an accurate account of what really happened from December 12th on, but that the IG's report covers more details, so the Review Panel either was not given pertinent information or the Review Panel wrote the Report so as to omit the accurate accounts.

   ***Response*:** The Report devotes three pages to describe the events of December 12-13. Part B of Chapter IV) describes in great detail the legal and mental health process involving Cho and the implications for future improvements. Part B alone contains 12 recommendations.

10. **Cho's emergency custody and transport to St. Albans:** Commenter states: the Report says officers transported Cho to St. Albans for admission at 11:00. Stewarts' (the IG) report says he was admitted at 11:15. It took VTPD 4 hours to take Cho into emergency custody after the magistrate issued the TDO.

Response: VTPD **immediately** took Cho **to police headquarters** for evaluation by a mental health prescreener who arrived shortly after being called. The prescreener took time interviewing Cho, the police, and Cho's roommates by phone, and found a psychiatric bed at St. Albans – then contacted the magistrate to request a TDO. The TDO was issued at 10:12 p.m. Cho was in custody at the Virginia Tech police station during this time. Police then left with Cho at 11:00 p.m. to travel to St. Albans. The hospital **admitted** Cho at 11:15.

11. **Screening form and box for "access to firearms" and finding of error:** Commenter states that the screening form released on 8/19/09 does not include a form with a box for firearm access and asks why it was not released and on what the Review Panel based its finding that the marked box was an error. Claims it is very likely that Cho had possession of a gun at that time.

    Response: Several intake and screening forms were used for Cho's evaluation and treatment process and release from Carillion St. Albans. The form completed by the CSB evaluator Kathy Godbey during her preliminary screening of Cho at VTPD includes the question on access to a firearm. The Review Panel was provided with a copy of that, and all other intake and screening forms. The Review Panel members interviewed Ms. Godbey who indicated that she might have inadvertently checked the wrong box, because if the "Yes" box is checked, then the evaluator must describe the access and the firearm, and she had not written anything on that line. There are no indications that Cho had possession of any gun until his purchase in early 2007.

12. **Information sent to CCC and staff emails:** Commenter notes there was an email between Emily Conway, a member of the CCC support staff and Dr. Miller at 4:24 on December 14, 2005, less than 45 minutes after Cho was seen and maintains the email was deliberately omitted.

    Response: The Report includes discussion of this email. There were two relevant communications at CCC on December 14, 2005. The first was the fax with the St. Albans discharge summary and CSB evaluator's report received shortly before Cho was seen at 3:00. The second was an email sent to Dr. Miller from Sandra Ward, the Director of Residence Life, which described the events of the previous night and Cho's transfer to St. Albans. Dr. Miller immediately forwarded this to CCC staff as an alert in case Cho came to CCC.

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Chapter V.
INFORMATION PRIVACY LAWS

While Cho was a student at Virginia Tech, his professors, fellow students, campus police, the Office of Judicial Affairs, the Care Team, and the Cook Counseling Center all had dealings with him that raised questions about his mental stability. There is no evidence that Cho's parents were ever told of these contacts, and they say they were unaware of his problems at school. Most significantly, there is no evidence that Cho's parents, his suitemates, and their parents were ever informed that he had been temporarily detained, put through a commitment hearing for involuntary admission, and found to be a danger to himself. Efforts to share this information was impeded by laws about privacy of information, according to several university officials and the campus police. Indeed, the university's attorney, during one of the panel's open hearings and in private meetings, told the panel that the university could not share this information due to privacy laws.

The panel's review of information privacy laws governing mental health, law enforcement, and educational records and information revealed widespread lack of understanding, conflicting practice, and laws that were poorly designed to accomplish their goals. Information privacy laws are intended to strike a balance between protecting privacy and allowing information sharing that is necessary or desirable. Because of this difficult balance, the laws are often complex and hard to understand.

The widespread perception is that information privacy laws make it difficult to respond effectively to troubled students. This perception is only partly correct. Privacy laws can block some attempts to share information, but even more often may cause holders of such information to default to the nondisclosure option—even when laws permit the option to disclose. Sometimes this is done out of ignorance of the law, and sometimes intentionally because it serves the purposes of the individual or organization to hide behind the privacy law. A narrow interpretation of the law is the least risky course, notwithstanding the harm that may be done to others if information is not shared.

Much of the frustration about privacy laws stems from lack of understanding. When seen clearly, the privacy laws contain many provisions that allow for information sharing where necessary. Also, FERPA and HIPAA are not consistent (Cook Counseling Center records come under FERPA, Carilion's under HIPAA), which causes difficulties, as explained below.

This chapter addresses federal and state law concerning four key categories of information that may be useful in evaluating and responding to a troubled student:

Law enforcement records
Court records
Medical information and records
Educational records.

The report also examines a Virginia law that regulates the process of disclosing information. These laws are discussed in the context of Cho's conduct leading to the shootings of April 16.

Appendix G summarizes the privacy laws as background for this chapter, for those unfamiliar with them.

LAW ENFORCEMENT RECORDS

Law enforcement agencies must disclose certain information to anyone who requests it.[3] They must disclose basic information about felony crimes: the date, location, general description of the crime, and name of the investigating officer. Law enforcement agencies also have to release the name and

[3] Va. Code § 2.2-3706

address of anyone arrested and charged with any type of crime. All records about noncriminal incidents are available upon request. When they close noncriminal incident records, law enforcement agencies must withhold personally-identifying information, such as names, addresses, and social security numbers.[4]

Universities with campus police departments have additional responsibilities. They are required to maintain a publicly available log that lists all crimes.[5] The log must give the time, date, and location of each offense, as well as the disposition of each case. Under Virginia law, campus police departments must also ensure that basic information about crimes is open to the public.[6] This includes the name and address of those arrested for felony crimes against people or property and misdemeanor crimes involving assault, battery, or moral turpitude.[7]

Most of the detailed information about criminal activity is contained in law enforcement investigative files. Under Virginia's Freedom of Information Act, law enforcement agencies are *allowed* to keep these records confidential. The law also gives agencies the discretion to release the records.[8] However, law enforcement agencies across the state typically have a policy against disclosing such records.

JUDICIAL RECORDS

As a general matter, court records are public and can be widely disclosed. For the purposes of responding to troubled students, two types of court proceedings do not fit the general rule: juvenile hearings and commitment hearings for involuntary admission.[9]

A commitment hearing for involuntary admission is a hearing where a judicial officer makes a determination as to whether an individual will be committed to a mental health facility involuntarily. Records of these hearings, which consist of any medical records, reports of evaluations, and all court documents, must be sealed when the subject of the hearing requests it. Tape recordings are made of the proceedings. The tapes are sealed and held by court clerks. These records can only be released by court order.[10]

Although their records are confidential, the hearings themselves must be open to the public and certain information about the hearing is, at least in theory, publicly available.[11] This would include the name of the subject and the time, date, and location of the hearing. Of course, there is no central location where this information is stored so, as a practical matter, unless an interested party knew where the hearing was being held or who was presiding over it, that person would have a difficult time uncovering such information. For example, Cho's commitment hearing occurred approximately 12 hours after he was detained. Logistical difficulties also make it difficult to visit psychiatric facilities, which are common locations for commitment hearings. The key, though, is that the information is public. In Cho's case, the Virginia Tech Police Department (VTPD) was aware that he had been detained pending a commitment hearing. VTPD could have shared this information with

[4] Law enforcement records regarding juveniles (persons under 18) have special restrictions regarding disclosure. Normally, they can only be released to other parts of the juvenile justice system or to parents of an underaged suspect. However, Virginia law also authorizes, but does not require, law enforcement to share information with school principals about offenders who commit a serious felony, arson, or weapons offense. Police can tell principals when they believe a juvenile is a suspect or when a juvenile is charged with an offense. After the case is finished, law enforcement officials can tell principals the outcome. Va. Code § 16.1-301

[5] 20 U.S.C. § 1092(f)(4)(A)

[6] Va. Code § 23-232.2(B)

[7] Va. Code § 23-232.2(B)

[8] Va. Code § 2.2-3706

[9] Va. Code § 17.1-208 (circuit court records open to the public). Regarding juvenile court records: under Virginia law, juvenile court records are even more tightly restricted than juvenile law enforcement records. Court records can only be used within the juvenile justice system unless a judge orders the records released. Va. Code § 16.1-305

[10] Va. Code § 37.2-818. Cho was the subject of a commitment hearing for involuntary admission on December 14, 2005. The panel obtained the tape recording and records of this hearing through court order.

[11] Va. Code § 37.2-820

university administration or Cho's parents, though they did not.

MEDICAL INFORMATION

Both state and federal law govern privacy of medical information. The federal Health surance and Portability and Accountability Act of 1996 and regulations by the Secretary of Health and Human Services establish the federal standards. Together, the law and regulations are commonly known as "HIPAA." Virginia law on medical information privacy is found in the Virginia Health Records Privacy Act (VHRPA).

HIPAA and Virginia law have similar standards. They both state that health information is private and can only be disclosed for certain reasons. When specific provisions conflict, HIPAA can preempt a state law, making the state law ineffective. Generally, this occurs when a state law attempts to be less protective of privacy than the federal law or rules.

Both laws apply to all medical providers and billing entities. They define "provider" broadly to include doctors, nurses, therapists, counselors, social workers, and health organizations such as HMOs and insurance companies, among others.

Three basic types of disclosures are permitted under these medical information privacy laws:

- Requests made or approved by the person who is the subject of the records. These exceptions are based on the idea that the privacy laws are for the benefit of the person being treated. If the patient asks for his or her records from a health care provider or provides written authorization, the provider must release them.
- Disclosure when information must be shared in order to make medical treatment effective. Medical privacy laws allow providers to share information with each other when necessary for treatment purposes.[12] If a medical provider needs to disclose information to a family member, the provider can do so in two ways. The provider can gain permission from the patient. Or, in an emergency where the patient is unable to make such a decision, the provider can proceed without explicit permission.[13]
- Situations where privacy is outweighed by certain other interests. For example, providers may sometimes disclose information about a person who presents an imminent threat to the health and safety of individuals and the public.[14] Providers can also disclose information to law enforcement in order to locate a fugitive or suspect.[15] Providers also are authorized to disclose information when state law requires it.[16]

Disclosure of information is required by state law in some situations and is permissible by HIPAA. An example under Virginia state law is that Virginia health care providers must report evidence of child abuse or neglect. Another type of required disclosure is when freedom of information laws require public agencies to disclose their records. If a freedom of information law requires a public hospital to disclose information, the disclosure is authorized under HIPAA.[17]

EDUCATIONAL RECORDS

Privacy of educational records is primarily governed by federal law, The Family Educational Rights and Privacy Act of 1974 and regulations issued by the Secretary of

[12] 45 C.F.R. § 164.506(c)(2); Va. Code § 32.1-127.1:03(D)(7)

[13] 45 C.F.R. § 164.510(b)

[14] 45 C.F.R. § 164.512(j)

[15] Va. Code § 32.1-127.1:03(D)(28)

[16] 45 C.F.R. § 164.512(a), (c)

[17] If, however, a state law merely *permits* disclosure, HIPAA usually will override state law and prevent disclosure. For example, Virginia's Freedom of Information Act gives public agencies the discretion to release information, but does not require information to be released. Because the decision is left to the discretion of the agency, HIPAA would prohibit disclosure.

Education that interpret the law. This law and the regulations are commonly known as "FERPA."

FERPA applies to all educational institutions that accept federal funding. As a practical matter, this means almost all institutions of higher learning, including Virginia Tech. It also includes public elementary and secondary schools. Like HIPAA, FERPA's basic rule favors privacy. Information from educational records cannot be shared unless authorized by law or with consent of a parent, or if the student is enrolled in college or is 18 or older, with that student's consent.

FERPA has special interactions for medical and law enforcement records. HIPAA also makes an exception for all records covered by FERPA. [18] Therefore, records maintained by campus health clinics are not covered by HIPAA.[19] Instead, FERPA and state law restrictions apply to these records.[20] FERPA provides the basic requirements for disclosure of health care records at campus health clinics, and state law cannot require disclosure that is not authorized by FERPA.[21] However, if FERPA authorizes disclosure, a campus health clinic would then have to look to state law to determine whether it could disclose records, including state laws on confidentiality of medical records.

For example, Virginia Tech's Cook Counseling Center holds records regarding Cho's mental health treatment. On a request for those records, the center must determine whether the disclosure is authorized under both FERPA and the Virginia Health Records Privacy Act. It is important to note that FERPA was drafted to apply to educational records, not medical records. Though it has a small number of provisions about medical records, FERPA does not enumerate the different types of disclosures authorized by HIPAA.

FERPA also has a different scope than HIPAA. Medical privacy laws such as HIPAA apply to all information—written or oral—gained in the course of treatment. FERPA applies only to information in student *records*. Personal observations and conversations with a student fall outside FERPA. Thus, for example, teachers or administrators who witness students acting strangely are not restricted by FERPA from telling anyone—school officials, law enforcement, parents, or any other person or organization.[22] In this case, several of Cho's professors and the Residence Life staff observed conduct by him that raised their concern. They would have been authorized to call Cho's parents to report the behavior they witnessed.

Many records kept by university law enforcement agencies also fall outside of FERPA. For example, it does not apply to records created and maintained by campus law enforcement for law enforcement purposes.[23] If campus law enforcement officers share a record with the school, however, the copy that is shared becomes subject to FERPA. For example, in fall 2005, VTPD received complaints from female students about Cho's behavior. Their records of investigation were created for the law enforcement purpose of investigating a potential crime. Accordingly, the police could have told Cho's parents of the incident. When the university's Office of Judicial Affairs requested the records, FERPA rules applied to the copies held in that office but not to any record retained by the VTPD.

[18] 45 C.F.R. § 160.103, definition of "protected health information."

[19] U.S. Department of Education, FERPA General Guidance for Parents, available at http://www.ed.gov/policy/gen/guid/fpco/ferpa/parents.html (attached as Appendix H) ("June 2007 ED Guidance").

[20] The nature of FERPA's application to treatment records has not been uniformly interpreted (discussed in the "Recommendations" section). The analysis in this section is based in part on an official letter sent to the University of New Mexico by the Family Policy Compliance Office (FPCO). The FPCO is the part of the Department of Education that officially interprets FERPA. The letter is included in Appendix G.

[21] Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Melanie P. Baise, Associate University Counsel, The University of New Mexico, dated November 29, 2004 (enclosed as Appendix G).

[22] June 2007 ED Guidance (Appendix H).

[23] 20 U.S.C. § 1232g(a)(4)(B)(ii)

Law enforcement performs various other functions that promote public order and safety. For example, law enforcement officers are usually responsible for transporting people who are under temporary detention orders to mental health facilities. No privacy laws apply to this law enforcement function. In the Cho case, the VTPD was not prohibited from contacting the university administration or Cho's parents to inform them that Cho was under a temporary detention order and had been transported to Carilion St. Albans Behavioral Health.

FERPA authorizes release of information to parents of students in several situations. First, it authorizes disclosure of any record to parents who claim adult students as dependents for tax purposes.[24] FERPA also authorizes release to parents when the student has violated alcohol or drug laws and is under 21.[25]

FERPA generally authorizes the release of information to school officials who have been determined to have a legitimate educational interest in receiving the information.[26] FERPA also authorizes unlimited disclosure of the final result of a disciplinary proceeding that concludes a student violated university rules for an incident involving a crime of violence (as defined under federal law) or a sex offense.[27] Finally, some FERPA exceptions regarding juveniles are governed by state law.[28]

FERPA also contains an emergency exception. Disclosure of information in educational records is authorized to any appropriate person in connection with an emergency "if the knowledge of such information is necessary to protect the health or safety of the student or other persons."[29] Although this exception does authorize sharing to a potentially broad group of parties, the regulations specifically state that it is to be narrowly construed. HIPAA, too, contains exceptions that allow disclosure in emergency situations.[30] For both laws, the exceptions have been construed to be limited to circumstances involving imminent, specific threats to health or safety. Troubled students may present such an emergency if their behavior indicates they are a threat to themselves or others. The Department of Education's Family Compliance Policy Office (FCPO) has advised that when a student makes suicidal comments, engages in unsafe conduct such as playing with knives or lighters, or makes threats against another student, the student's conduct can amount to an emergency (see letter in Appendix G).[31] However, the boundaries of the emergency exceptions have not been defined by privacy laws or cases, and these provisions may discourage disclosure in all but the most obvious cases.

GOVERNMENT DATA COLLECTION AND DISSEMINATION PRACTICES ACT

One other law on information disclosure applies to most Virginia government agencies. The Government Data Collection and Dissemination Practices Act establishes rules for collection, maintenance, and dissemination of individually-identifying data. The act does not apply to police departments or courts. Agencies that are bound by the act can only disclose information when permitted or required by law.[32] The attorney general of Virginia has interpreted "permitted by law" to include any official request made by a government agency for a lawful function of the agency. An agency must inform people who

[24] 20 U.S.C. § 1232g(b)(1)(H); 34 C.F.R. § 99.31(a)(8)

[25] 20 U.S.C. § 1232g(i)

[26] 20 U.S.C. § 1232g(b)(1)(A); 34 C.F.R. § 99.31(a)(1)

[27] 20 U.S.C. § 1232g(b)(6)(B)

[28] 20 U.S.C. § 1232g(b)(1)(E); Va. Code § 22.1-287. Virginia law authorizes disclosure to law enforcement officers seeking information in the course of his or her duties, court services units, mental health and medical health agencies, and state or local children and family service agencies.

[29] 20 U.S.C. § 1232g(b)(1)(I)

[30] 45 C.F.R. § 164.512(j); Va. Code § 32.1-127.1:03(D)(19); § 32.1-127.1:04; 20 U.S.C. § 1232g(b)(1)(I)

[31] Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Superintendent, New Bremen Local Schools, dated September 24, 1994 (enclosed as Appendix G).

[32] Va. Code § 2.2-3803(A)(1)

give it personal information how it will ordinarily use and share that information. An agency can disclose personal information outside of these ordinary uses. When it does, however, it must give notice to the people who provided the information.[33] This act was initially used as a reason for not providing information to the panel until its authenticity was strengthened by the governor's executive order.

KEY FINDINGS

Organizations and individuals must be able to intervene in order to assist a troubled student or protect the safety of other students. Information privacy laws that block information sharing may make intervention ineffective.

At the same time, care must be taken not to invade a student's privacy unless necessary. This means there are two goals for information privacy laws: they must allow enough information sharing to support effective intervention, and they must also maintain privacy whenever possible.

Effective intervention often requires participation of parents or other relatives, school officials, medical and mental health professionals, court systems, and law enforcement. The problems presented by a seriously troubled student often require a group effort. The current state of information privacy law and practice is inadequate to accomplish this task. The first major problem is the lack of understanding about the law. The next problem is inconsistent use of discretion under the laws. Information privacy laws cannot help students if the law allows sharing but agency policy or practice forbids necessary sharing. The privacy laws need amendment and clarification. The panel proposes the following recommendations to address immediate problems and chart a course for an effective information privacy system.

RECOMMENDATIONS

V-1 Accurate guidance should be developed by the attorney general of Virginia regarding the application of information privacy laws to the behavior of troubled students. The lack of understanding of the laws is probably the most significant problem about information privacy. Accurate guidance from the state attorney general's office can alleviate this problem. It may also help clarify which differences in practices among schools are based on a lack of understanding and which are based on institutional policy. For example, a representative of Virginia Tech told the panel that FERPA prohibits the university's administrators from sharing disciplinary records with the campus police department. The panel also learned that the University of Virginia has a policy of sharing such records because it classifies its chief of police as an official with an educational interest in such records.

The development of accurate guidance that signifies that law enforcement officials may have an educational interest in disciplinary records could help eliminate discrepancies in the application of the law between two state institutions. The guidance should clearly explain what information can be shared by concerned organizations and individuals about troubled students. The guidance should be prepared and widely distributed as quickly as possible and written in plain English. Appendix G provides a copy of guidance issued by the Department of Education in June 2007, which can serve as a model or starting point for the development of clear, accurate guidance.

V-2 Privacy laws should be revised to include "safe harbor" provisions. The provisions should insulate a person or organization from liability (or loss of funding) for making a disclosure with a good faith belief that the disclosure was necessary to protect the health, safety, or welfare of the person involved or members of the general public. Laws protecting good-faith disclosure for health, safety, and welfare can help combat any bias toward nondisclosure.

[33] Va. Code § 2.2-3806(A)(2)

V-3 The following amendments to FERPA should be considered:

FERPA should explicitly explain how it applies to medical records held for treatment purposes. Although the Department of Education interprets FERPA as applying to all such records,[34] that interpretation has not been universally accepted. Also, FERPA does not address the differences between medical records and ordinary educational records such as grade transcripts. It is not clear whether FERPA preempts state law regarding medical records and confidentiality of medical information or merely adds another requirement on top of these records.

FERPA should make explicit an exception regarding treatment records. Disclosure of treatment records from university clinics should be available to any health care provider without the student's consent when the records are needed for medical treatment, as they would be if covered under HIPAA. As currently drafted, it is not clear whether off-campus providers may access the records or whether students must consent. Without clarification, medical providers treating the same student may not have access to health information. For example, Cho had been triaged twice by Cook Counseling Center before being seen by a provider at Carilion St. Albans in connection with his commitment hearing. Later that day, he was again triaged by Cook. Carilion St. Albans's records were governed by HIPAA. Under HIPAA's treatment exception, Carilion St. Albans was authorized to share records with Cook. Cook's records were governed by FERPA. Because FERPA's rules regarding sharing records for treatment are unclear about outside entities or whether consent is necessary, Carilion St. Albans could not be assured that Cook would share its records. This situation makes little sense.

V-4 The Department of Education should allow more flexibility in FERPA'a "emergency" exception. As currently drafted, FERPA contains an exception that allows for release of records in an emergency, when disclosure is necessary to protect the health or safety of either the student or other people. At first, this appears to be an exception well-suited to sharing information about seriously troubled students. However, FERPA regulations also state that this exception is to be strictly construed. The "strict construction" requirement is unnecessary and unhelpful. The existing limitations require that an emergency exists and that disclosure is necessary for health or safety. Further narrowing of the definition does not help clarify when an emergency exists. It merely feeds the perception that nondisclosure is always a safer choice.

V-5 Schools should ensure that law enforcement and medical staff (and others as necessary) are designated as school officials with an educational interest in school records. This FERPA-related change does not require amendment to law or regulation. Education requires effective intervention in the lives of troubled students. Intervention ensures that schools remain safe and students healthy. University policy should recognize that law enforcement, medical providers, and others who assist troubled students have an educational interest in sharing records. When confirmed by policy, FERPA should not present a barrier to these entities sharing information with each other.

V-6 The Commonwealth of Virginia Commission on Mental Health Reform should study whether the result of a commitment hearing (whether the subject was voluntarily committed, involuntarily committed, committed to outpatient therapy, or released) should also be publicly available despite an individual's request for confidentiality. Although this information would be helpful in tracking people going though the system, it may infringe too much on their privacy.

As discussed in Chapter IV, and its recommendations to revise Virginia law regarding the commitment process, the law governing hearings should explicitly state that basic

[34] June 2007 ED Guidance (Appendix H).

information regarding a commitment hearing (the time, date, and location of the hearing and the name of the subject) is publicly available even when a person requests that records remain confidential. This information is necessary to protect the public's ability to attend commitment hearings.

V-7 The national higher education associations should develop best practice protocols and associated training for information sharing. Among the associations that should provide guidance to the member institutions are:

- American Council on Education (ACE)
- American Association of State Colleges and Universities (AASCU)
- American Association of Community Colleges (AACE)
- National Association of State and Land Grant Universities and Colleges (NASLGUC)
- National Association of Independent Colleges and Universities (NAICU)
- Association of American Universities (AAU)
- Association of Jesuit Colleges and Universities

If the changes recommended above are implemented, it is possible that no further changes to privacy laws would be necessary, but guidance on their interpretation will be needed. The unknown variable is how entities will choose to exercise their discretion when the law gives them a choice on whether to share or withhold information. How an institution uses its discretion can be critically important to whether it is effectively able to intervene in the life of a troubled student. For example, FERPA currently allows schools to release information in their records to parents who claim students as dependents. Schools are not, however, required to release that information. Yet, if a university adopts a policy against release to parents, it cuts off a vital source of information. The history of Seung Hui Cho shows the potential danger of such an approach. During his formative years, Cho's parents worked with Fairfax County school officials, counselors, and outside mental health professionals to respond to episodes of unusual behavior. Cho's parents told the panel that had they been aware of his behavioral problems and the concerns of Virginia Tech police and educators about these problems, they would again have become involved in seeking treatment. The people treating and evaluating Cho would likely have learned something (but not all) of his prior mental health history and would have obtained a great deal of information germane to their evaluation and treatment of him. There is no evidence that officials at Virginia Tech consciously decided not to inform Cho's parents of his behavior; regardless of intent, however, they did not do so. The example demonstrates why it may be unwise for an institution to adopt a policy barring release of information to parents.

The shootings of April 16, 2007, have forced all concerned organizations and individuals to reevaluate the best approach for handling troubled students. Some educational institutions in Virginia have taken the opportunity to examine the difficult choices involved in attempts to share necessary information while still protecting privacy. Effort should be made to identify the best practices used by these schools and to ensure that these best practices are widely taught. All organizations and individuals should be urged to employ their discretion in appropriate ways, consistent with the best practices. Armed with accurate guidance, amended laws, and a new sense of direction, it is an ideal time to establish best practices for intervening in the life of troubled students.

ADDITIONS AND CORRECTIONS

(No changes from original report.).

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Chapter VI.
GUN PURCHASE AND CAMPUS POLICIES

In investigating the role firearms played in the events of April 16, 2007, the panel encountered strong feelings and heated debate from the public. The panel's investigation focused on two areas: Cho's purchase of firearms and ammunition, and campus policies toward firearms. The panel recognizes the deep divisions in American society regarding the ready availability of rapid fire weapons and high capacity magazines, but this issue was beyond the scope of this review.

FIREARMS PURCHASES

Every person killed at Cho's hands on April 16 was shot with one of two firearms, a Glock 19 9mm pistol or a Walther P22 .22 caliber pistol. Both weapons are semiautomatic, which meant that once loaded, they fire a round with each pull of the trigger, rather than being able to fire continuously by holding the trigger down. Cho purchased the Walther P22 first—by placing an online order with the TGSCOM, Inc., a company that sells firearms over the Internet. Cho then picked up the pistol on February 9, 2007, at J-N-D Pawn-brokers in Blacksburg, which is located just across Main Street from the Virginia Tech campus.

Cho purchased the Glock a month later, on March 13, from Roanoke Firearms in Roanoke. Virginia law limits handgun purchases to one every 30 days, which he may have known judging by this spacing.[35] Cho made his purchases using a credit card. Although his parents gave him money to pay for his expenses, they said they did not receive his credit card bills and did not know what he purchased. They stated that the only time they received an actual billing statement was after his death, and at that point the total bill was over $3,000.

On March 22, 2007, shortly after purchasing the Glock, Cho went to PSS Range and Training, an indoor pistol range in Roanoke. Cho practiced shooting for about an hour.

Cho was not legally authorized to purchase his firearms, but was easily able to do so. Gun purchasers in Virginia must qualify to buy a firearm under both federal and state law. Federal law disqualified Cho from purchasing or possessing a firearm. The federal Gun Control Act, originally passed in 1968, prohibits gun purchases by anyone who has "has been adjudicated as a mental defective or who has been committed to a mental institution."[36] Federal regulations interpreting the act define "adjudicated as a mental defective" as "[a] determination by a court, board, commission, or other lawful authority that a person, as a result of …mental illness …[i]s a danger to himself or to others."[37] Cho was found to be a danger to himself by a special justice of the Montgomery County General District Court on December 14, 2005. Therefore, under federal law, Cho could not purchase any firearm.

The legal status of Cho's gun purchase under Virginia law is less clear. Like federal law, Virginia law also prohibits persons who have been adjudged incompetent or committed to mental institutions from purchasing firearms.[38] However, Virginia law defines the terms differently. It defines incompetency by referring to the section of Virginia Code for declaring a person incapable of caring for himself or herself.[39] It does not specify that a person who had been found to be a danger to self or others is "incompetent." Because he had not been declared unable to care for himself, it does not appear that Cho was disqualified under this provision of Virginia law.

[35] Va. Code § 18.1-308.2:2(P)

[36] 18 U.S.C. § 922(g)(4)

[37] 27 C.F.R. § 478.11

[38] Va. Code §§ 18.2-308.1:2 and 3

[39] Va. Code § 18.2-308.1:2, citing Va. Code 37.2-1000 et seq.

Virginia law also prohibits "any person who has been involuntarily committed pursuant to Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2" from purchasing or possessing a firearm.[40] This section authorizes a court to order either inpatient or outpatient treatment. When a person is ordered into a hospital, the law is relatively straightforward—the person has been "involuntarily committed." What is not clear from the statute, however, is whether a person such as Cho, who was found to be a danger to self or others and ordered to receive outpatient treatment, qualifies as being involuntarily committed. Among the mental health community, "involuntary outpatient commitment" is a recognized term for an order for outpatient treatment. In practical terms, a person who is found to be an imminent danger to self or others and ordered into outpatient treatment is little different than one ordered into inpatient treatment. However, the statute does not make clear whether outpatient treatment is covered. Thus, Cho's right to purchase firearms under Virginia law was not clear.

This uncertainty in Virginia law carries over into the system for conducting a firearms background check. In general, nationally, before purchasing a gun from a dealer a person must go through a background check. A government agency runs the name of the potential buyer through the databases of people who are disqualified from purchasing guns. If the potential purchaser is in the database, the transaction is stopped. If not, the dealer is instructed to proceed with the sale. The agency performing the check varies by state. Some states rely on the federal government to conduct the checks. In others, the state and the federal government both do checks. In yet other states, such as Virginia, the state conducts the check of both federal and state databases. In Virginia the task is given to the state police.

Because purchasers have to be eligible under both state and federal law, potential buyers in Virginia have to fill out two forms: the federal "Firearms Transaction Record" (ATF 4473) and the Virginia Firearms Transaction Record (SP 65.) (Copies of the forms are provided in Appendix I.) The forms collect basic information about the potential buyer, such as name, age, and social security number. Each form also asks questions to determine whether a buyer is eligible to purchase a weapon. Form 4473 asks 11 questions, such as whether the buyer has been convicted of a felony. SP 65 contains questions and information regarding Virginia law, such as whether restraining orders were issued that disqualify purchasers. Firearms dealers initiate the background check by transmitting information from the forms to the state police's Firearms Transaction Program.

Certain firearms transfers do not require background checks at all. Virginia law does not require background checks for personal gifts or sales by private collectors, including transactions by collectors that occur at gun shows.

In Virginia, the Central Criminal Records Exchange (CCRE), a division of the state police, is tasked with gathering criminal records and other court information that is used for the background checks. Information on mental health commitment orders "for involuntary admission to a facility" is supposed to be sent to the CCRE by court clerks, who must send all copies of the orders along with a copy of form SP 237 that provides basic information about the person who is the subject of the order.[41] As currently drafted, the law only requires a clerk to certify a form, and does not specify who should complete the form. Because of the lack of clarity, it was reported to the panel that clerks in some jurisdictions do not send the information unless they receive a completed form. Recommendations to improve this aspect of the law were given in Chapter IV.

The meaning of the term "admission to a facility" is less clear than it might seem. The law appears on an initial reading to only include orders requiring a person to receive inpatient care. This reading seems to have support from the Virginia

[40] Va. Code § 18.2-308.1:3

[41] Va. Code § 37.2-819

involuntary commitment statute. That law uses "admission to a facility" when describing inpatient treatment, not outpatient treatment.[42] But the law is actually more complex. Laws about mental health commitment and sending orders to CCRE all appear in Title 37.2 of the Virginia Code. The definitions for that title state that facility "means a state or licensed hospital, training center, psychiatric hospital, or other type of residential or outpatient mental health or mental retardation facility."[43] So while the most obvious reading of the law is that only inpatient orders should be sent to CCRE, the actual requirement is unclear.

At the time Cho purchased his weapons, the general understanding was that only inpatient orders had to be sent to CCRE. Probably due to this understanding, the special justice's December 14, 2005, order finding Cho to be a danger to himself was not reported to the firearms background check system. Although the law may have been ambiguous, the checking process was not. Either you are or are not in the database when a gun purchase request form is submitted, and Cho was not.

There does not seem to have been an appreciation in setting up this process that the federal mental health standards were different than those of the state or that the practice deprived the federal database of information it needed in order to make the system effective. Thus on February 9 and March 13, 2007, Cho, a person disqualified under federal law from purchasing a firearm, walked into two licensed firearms dealers. He filled out the required forms. The dealers entered his information into the background check system. Both checks told the dealers to proceed with the transaction. Minutes after both checks, Cho left the stores in possession of semiautomatic pistols.

The FBI indicated in a press release dated April 19, 2007, that just 22 states reported any mental health information to the federal database. Ironically, the FBI cited Virginia as the state that provided the most information on people disqualified due to mental deficiency.[44]

In the days following the killings at Virginia Tech, Governor Kaine moved to clarify the law regarding inclusion of outpatient treatment into the database. Executive Order 50 now requires executive branch employees, including the state police, to collect information on outpatient orders and to treat such orders as disqualifications to owning a firearm. The state police revised SP 237 to ensure that they receive information regarding out-patient orders. Copies of the older and revised versions of SP 237 are presented in Appendix J. As previously discussed in Chapter IV, the panel recommends that the General Assembly clarify the relevant laws in this regard to permanently reflect the interpretation of Executive Order 50.

It is not clear whether Cho knew that he was prohibited from purchasing firearms. ATF 4473 asks each potential purchaser "[h]ave you ever been adjudicated mentally defective (which includes having been adjudicated incompetent to manage your own affairs) or have you ever been committed to a mental institution?" The state and federal forms that Cho filled out are currently held by the Virginia state police in their case investigation file, but were destroyed in the CCRE file, as required after 30 days. The state police did not permit the panel to view copies of the forms in their investigation file but indicated that Cho answered "no" to this question on both forms. It is impossible to know whether Cho understood that the proper response was "yes" and whether his answers were mistakes or deliberate falsifications. In any event, the fact remains that Cho, a person disqualified from purchasing firearms, was readily able to obtain them.

[42] Va. Code § 37.2-817. Paragraph B describes inpatient orders and uses the term "admitted to a facility"; paragraph C authorizes outpatient commitment but does not use the term "admitted to a facility."

[43] Va. Code. § 37.2-100

[44] The panel notes that the federal law terminology referring to mentally ill persons as "mentally defective" is outmoded based on current medical and societal understanding of mental health.

AMMUNITION PURCHASES

Cho purchased ammunition on several occasions in the weeks and months leading up to the shootings. On March 13, 2007, he purchased a $10 box of practice ammunition from Roanoke Firearms at the same time he bought his Glock 9mm pistol. On March 22 and 23, he purchased a total of five 10-round magazines for the Walther on the Internet auction site eBay. In addition, Cho purchased several 15-round magazines along with ammunition and a hunting knife on March 31 and April 1 at local Wal-Mart and Dick's Sporting Goods stores. With these magazines loaded, Cho would be able to fire 15 rounds, eject the magazine, and load a fresh one in a matter a moments. By the time he walked into Norris Hall, Cho had almost 400 bullets in magazines and loose ammunition.

Federal law prohibited Cho from purchasing ammunition. Just as it prohibits anyone from purchasing a gun who has been found to be a danger to self or others, it prohibits the same individuals from buying ammunition.[45] However, unlike firearms, there is no background check associated with purchasing ammunition. Neither does Virginia law place any restrictions on who can purchase ammunition. It does prohibit the use of some types of ammunition while committing a crime, but does not regulate the purchase of such ammunition.[46] Cho did not use any special types of ammunition that are restricted by law.

The panel also considered whether the previous federal Assault Weapons Act of 1994 that banned 15-round magazines would have made a difference in the April 16 incidents. The law lapsed after 10 years, in October 2004, and had banned clips or magazines with over 10 rounds. The panel concluded that 10-round magazines that were legal would have not made much difference in the incident. Even pistols with rapid loaders could have been about as deadly in this situation.

[45] 18 U.S.C § 922(d)(4)

[46] Va. Code § 18.2-308.3

GUNS ON CAMPUS

Virginia Tech has one of the tougher policy constraints of possessing guns on campus among schools in Virginia. However, there are no searches of bags or use of magnetometers on campus like there are in government offices or airports. Cho carried his weapons in violation of university rules, and probably knew that it was extremely unlikely that anyone would stop him to check his bag. He looked like many others.

Virginia universities and colleges do not seem to be adequately versed in what they can do about banning guns on campus under existing interpretations of state laws. The governing board of colleges and universities can set policies on carrying guns. Some said their understanding is that they must allow anyone with a permit to carry a concealed weapon on campus. Others said they thought guns can be banned from buildings but not the grounds of the institution. Several major universities reported difficulty understanding the rules based on their lawyers' interpretation. Most believe they can set rules for students and staff but not the general public. Virginia Tech, with approval of the state Attorney General's Office, had banned guns from campus altogether.

This issue came to a head at one of the panel's public meetings held at George Mason University. It was known that many advocates of the right to carry concealed weapons on campus were planning to attend the meeting carrying weapons to make a point. GMU did not know they could have established a policy to stop the weapons from being carried into their buildings.

The Virginia Tech total gun ban policy was instituted a few years ago when it was accidentally discovered that a student playing the role of a patient in a first aid drill was carrying a concealed weapon. That student, now a Virginia Tech graduate with a master's degree in engineering, stated to the panel that he started carrying a weapon after witnessing assaults and hearing about other crimes on the Virginia Tech campus. He and other students told the panel

that they felt it was safer for responsible people to be armed so they could fight back in exactly the type of situation that occurred on April 16. They might have been able to shoot back and protect themselves and others from being injured or killed by Cho. The guns-on-campus advocates cited statistics that overall there are fewer killings in environments where people can carry weapons for self-defense. Of course if numerous people had been rushing around with handguns outside Norris Hall on the morning of April 16, the possibility of accidental or mistaken shootings would have increased significantly. The campus police said that the probability would have been high that anyone emerging from a classroom at Norris Hall holding a gun would have been shot.

Data on the effect of carrying guns on campus are incomplete and inconclusive. The panel is unaware of any shootings on campus involving people carrying concealed weapons with permits to do so. Likewise, the panel knows of no case in which a shooter in campus homicides has been shot or scared off by a student or faculty member with a weapon. Written articles about a campus shooting rarely if ever comment on permits for concealed weapons, so this has been difficult to research. It may have happened, but the numbers of shootings on campuses are relatively few—about 16 a year at approximately 4,000 colleges and universities, according to the U.S. Department of Education Campus Crime Statistics for 2002–2004. It could be argued that if more people carried weapons with permits, the few cases of shootings on campus might be reduced further.

On the other hand, some students said in their remarks to the panel that they would be uncomfortable going to class with armed students sitting near them or with the professor having a gun. People may get angry even if they are sane, law-abiding citizens; for example, a number of police officers are arrested each year for assaults with weapons they carry off duty, as attested to by stories in daily newspapers and other media.

Campus police chiefs in Virginia and many chief-level officers in the New York City region who were interviewed voiced concern that as the number of weapons on campuses increase, sooner or later there would be accidents or assaults from people who are intoxicated or on drugs who either have a gun or interact with someone who does. They argued that having more guns on campus poses a risk of leading to a greater number of accidental and intentional shootings than it does in averting some of the relatively rare homicides. (See Appendix K for an article about the recent discharge of a gun by someone intoxicated in a fraternity house. Although a benign incident, it illustrates the concern.)

The panel heard a presentation from Dr. Jerald Kay, the chair of the committee on college mental health of the American Psychiatric Association about the large percentage of college students who binge drink each year (about 44 percent), and the surprisingly large percentage of students who claim they thought about suicide (10 percent). College years are full of academic stress and social stress. The probability of dying from a shooting on campus is smaller than the probability of dying from auto accidents, falls, or alcohol and drug overdoses.

KEY FINDINGS

Cho was able to purchase guns and ammunition from two registered gun dealers with no problem, despite his mental history.

Cho was able to kill 31 people including himself at Norris Hall in about 10 minutes with the semiautomatic handguns at his disposal. Having the ammunition in large capacity magazines facilitated his killing spree.

There is confusion on the part of universities as to what their rights are for setting policy regarding guns on campus.

RECOMMENDATIONS

VI-1 All states should report information necessary to conduct federal background checks on gun purchases. There should be federal incentives to ensure compliance. This should apply to states whose requirements are different from federal law. States should become fully compliant with federal law that disqualifies persons from purchasing or possessing firearms who have been found by a court or other lawful authority to be a danger to themselves or others as a result of mental illness. Reporting of such information should include not just those who are disqualified because they have been found to be dangerous, but all other categories of disqualification as well. In a society divided on many gun control issues, laws that specify who is prohibited from owning a firearm stand as examples of broad agreement and should be enforced.

VI-2 Virginia should require background checks for all firearms sales, including those at gun shows. In an age of widespread information technology, it should not be too difficult for anyone, including private sellers, to contact the Virginia Firearms Transaction Program for a background check that usually only takes minutes before transferring a firearm. The program already processes transactions made by registered dealers at gun shows. The practice should be expanded to all sales. Virginia should also provide an enhanced penalty for guns sold without a background check and later used in a crime.

VI-3 Anyone found to be a danger to themselves or others by a court-ordered review should be entered in the Central Criminal Records Exchange database regardless of whether they voluntarily agreed to treatment. Some people examined for a mental illness and found to be a potential threat to themselves or others are given the choice of agreeing to mental treatment voluntarily to avoid being ordered by the courts to be treated involuntarily. That does not appear on their records, and they are free to purchase guns. Some highly respected people knowledgeable about the interaction of mentally ill people with the mental health system are strongly opposed to requiring voluntary treatment to be entered on the record and be sent to a state database. Their concern is that it might reduce the incentive to seek treatment voluntarily, which has many advantages to the individuals (e.g., less time in hospital, less stigma, less cost) and to the legal and medical personnel involved (e.g., less time, less paperwork, less cost). However, there still are powerful incentives to take the voluntary path, such as a shorter stay in a hospital and not having a record of mandatory treatment. It does not seem logical to the panel to allow someone found to be dangerous to be able to purchase a firearm.

VI-4 The existing attorney general's opinion regarding the authority of universities and colleges to ban guns on campus should be clarified immediately. The universities in Virginia have received or developed various interpretations of the law. The Commonwealth's attorney general has provided some guidance to universities, but additional clarity is needed from the attorney general or from state legislation regarding guns at universities and colleges.

VI-5 The Virginia General Assembly should adopt legislation in the 2008 session clearly establishing the right of every institution of higher education in the Commonwealth to regulate the possession of firearms on campus if it so desires. The panel recommends that guns be banned on campus grounds and in buildings unless mandated by law.

VI-6 Universities and colleges should make clear in their literature what their policy is regarding weapons on campus. Prospective students and their parents, as well as university staff, should know the policy related to concealed weapons so they can decide whether they prefer an armed or arms-free learning environment.

ADDITIONS AND CORRECTIONS

Testimony on Shooting Incidence on Campuses: p. 75, Clarification – A question was received on the relevancy of testimony by Dr. Jerald Kay on the frequency of shootings on campuses—whether its inclusion was an attempt to downplay the seriousness of the Virginia Tech shootings in light of other dangers to students such as drunk driving.

The Review Panel invited Dr. Kay's presentation for two reasons: First to consider the risk from guns as part of the larger picture of campus emergency planning. The Review Panel wanted colleges and universities to consider, as part of emergency planning, the whole range of threats and their likelihood, not just guns. Second, this testimony was of interest as part of the discussion of whether guns should be allowed to be carried on campuses. The frequency and nature of shootings on campus was very relevant to the deliberations of the Review Panel in making recommendations regarding these issues. It also was relevant in understanding the risk of a further shooting faced by the Policy Group after the double homicide.

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Chapter VII.
DOUBLE MURDER AT WEST AMBLER JOHNSTON

This chapter discusses the double homicide at West Ambler Johnston (WAJ) residence hall and the police and university actions taken in response. It covers the events up to the shootings in Norris Hall, which are presented in the next chapter.

APPROACH AND ATTACK

Cho left his dormitory early in the morning of April 16, 2007 and went to the WAJ, about a 2-minute walk. He was seen outside WAJ by a student about 6:45 a.m. Figure 3 shows the exterior of WAJ and Figure 4, a typical hallway inside WAJ.

Figure 3. Exterior of West Ambler Johnston

Because Cho's student mailbox was located in the lobby of WAJ, he had access to that dormitory with his pass card, but only after 7:30 a.m.

Cho somehow gained entrance to the dormitory, possibly when a student coming out let him in or by tailgating someone going in. (No one remembers having done so, or admits it.)

Cho went to the fourth floor by either stairway or elevator to the room of student Emily Hilscher.

Figure 4. Hallway Outside Dorm Rooms in West Ambler Johnston

She had just returned with her boyfriend, a student at Radford University who lived in Blacksburg. He drove her back to her dorm, saw her enter, and drove away. She entered at 7:02 a.m., based on swipe card records, which also showed that she used a different entrance than Cho did. Although it is known that Cho previously stalked female students, including one in WAJ on her floor, the police have found no connection between Cho and Hilscher from any written materials, dorm mates, other friends of his or hers, or any other source.

As of this writing, the police still had found no motive for the slaying.

Figure 5. Typical Dorm Room in Ambler Johnston Hall

Not long after 7:15 a.m., noises emanating from Hilscher's room were loud enough and of such a disturbing nature that resident advisor Ryan Clark, who lived next door, checked to see what was happening. The presumption is that he came to investigate, saw Cho, and was killed to stop any interference with the shooter and his identification. Both Hilscher and Clark were shot by Cho at close range. (Figure 5 shows a typical dorm room in WAJ.)

The sounds of the shots or bodies falling were misinterpreted by nearby students as possibly someone falling out of a loft bed, which had happened before. A student in a nearby room called the Virginia Tech Police Department (VTPD), which dispatched a police officer and an emergency medical service (EMS) team—standard protocol for this type of call. The police received the call at 7:20 a.m. and arrived outside at 7:24 a.m. (an EMS response under 5 minutes for dispatch plus travel time is better than average, even in a city).[47] The EMS team arrived on scene at 7:26 and at the dorm room at 7:29. As soon as the police officer arrived and saw the gunshot wounds, he called for additional police assistance. Hilscher was transported to Montgomery Regional Hospital where she received care, and then transferred to Carilion Roanoke Memorial Hospital where she died. Clark was treated en route to Montgomery Regional Hospital, but could not be resuscitated by the emergency medical technicians (EMTs) and was pronounced dead shortly after arrival at the hospital. Their wounds were considered nonsurvivable at the time and in retrospect.

In the meantime, Cho somehow exited the building. No one reported seeing him leaving, according to police interviews of people in the dorm at the time. His clothes and shoes were bloodied, and he left bloody footprints in and coming out of the room. His clothes were found later in his room. Students were getting ready for 8:00 a.m. classes, but no one reported seeing Cho. Figure 6 shows the door to Hilscher's dorm room, with a peephole typical of others on that floor.

When Chief Wendell Flinchum of the VTPD learned of the incident at 7:40 a.m., he called for additional resources from the Blacksburg Police Department (BPD). A detective for investigation and an evidence technician headed for the scene. Chief Flinchum notified the office of the executive vice president at 7:57 a.m., after obtaining more information on what was found.

Immediately after they arrived, police started interviewing students in the rooms near Hilscher's room, and essentially locked down the building, with police inside and outside. (The

[47] This is based on data from 150 TriData studies of fire and EMS departments over 25 years. The National Fire Protection Association standard calls for a fire or EMS response in 5 minutes (1 minute turnout time, 4 minutes travel time) in 90 percent of calls, but few agencies meet that objective.

Figure 6. Emily Hilscher's Door With Peephole

exterior dorm doors were still locked from the usual nighttime routine.) A female friend of Hilscher came to the dorm to accompany her to class, as was their common practice, and she was immediately questioned by the police. She reported that Hilscher had been visiting her boyfriend, knew of no problems between them, and that Hilscher's boyfriend owned a gun and had been practicing on a target range with it. She knew his name and the description of his vehicle and that he usually drove her back to the dorm. The boyfriend was immediately considered a "person of interest."[48] Because he had been the last known person to see her before the shooting, he was the natural starting point for an investigation. No one had seen him drop her off. (The fact that he had dropped her off was established more than an hour later, after he was questioned.) The police then sent out a BOLO (be on the lookout) alert for his pickup truck and searched for it in the campus parking lots but could not find it. This implied that the only known person of interest had likely left the campus. There were no other leads at that time.

The police had no evidence other than shell casings in the room, the footprints, and the victims. The VTPD police chief said that this murder might have taken a long time to solve, if ever, for lack of evidence and witnesses. After the second incident occurred, the gun was identified by ATF as having been the same one used in the first shooting, but that was hindsight. If Cho had stopped after the first two shootings, he might well have never been caught.

PREMATURE CONCLUSION?

At this point, the police may have made an error in reaching a premature conclusion that their initial lead was a good one, or at least in conveying that impression to the Virginia Tech
administration. While continuing their investigation, they did not take sufficient action to deal with what might happen if the initial lead proved false. They conveyed to the university Policy Group that they had a good lead and that the person of interest was probably not on campus. (That is how the Policy Group understood it, according to its chair and other members who were interviewed by the panel and who presented information at one of its open hearings.) After two people were shot dead, police needed to consider the possibility of a murderer loose on campus who did a double slaying for unknown reasons, even though a domestic disturbance was a likely possibility. The police did not urge the Policy Group to take precautions, as best can be understood from the panel's interviews.

It was reasonable albeit wrong that the VTPD thought this double murder was most likely the result of a domestic argument, given the facts they had initially, including the knowledge that the last person known to have been with the female victim was her boyfriend who owned a gun and cared greatly for her, according to police interviews, plus the fact that she was shot

[48] "Person of interest" means someone who might be a suspect or might have relevant information about a crime.

with a young man in her room under the circumstances found.

There are very few murders each year on campuses—an average of about 16 across 4,000 universities and colleges, as previously noted. The only college campus mass murder in the United States in the past 40 years was the University of Texas tower sniper attack, though there have been occasional multiple murders. Based on past history, the probability of more shootings following a dormitory slaying was very low. The panel researched reports of multiple shootings on campuses for the past 40 years, and no scenario was found in which the first murder was followed by a second elsewhere on campus. (See Appendix L for a summary of the multiple criminal shootings on campus.) The VTPD had the probabilities correct, but needed to consider the low-probability side as well as the most likely situation.

Both the VTPD and the BPD immediately put their emergency response teams (ERTs) (i.e., SWAT teams) on alert and staged them at locations from which they could respond rapidly to the campus or city. They also had police on campus looking for the gunman while they pursued the boyfriend. The ERTs were staged mainly in case they had to make an arrest of the gunman or serve search warrants on the shooting suspect.

DELAYED ALERT TO UNIVERSITY COMMUNITY

The VTPD chief and BPD chief both responded to the murder scene in minutes. Chief Flinchum of the VTPD arrived at 8:00 a.m. and Chief Crannis of the BPD arrived at 8:13 a.m. As noted above, the VTPD chief had notified the university administration of the shootings at 7:57 a.m., just before he arrived at the scene.

Once informed, the university president almost immediately convened the emergency Policy Group to decide how to respond, including how and when to notify the university community. In an interview with President Steger, members of the panel were told that the police reports to the Policy Group first described a possible "murder–suicide" and then a "domestic dispute," and that the police had identified a suspect. After the area parking lots had been searched, the police reported the suspect probably had left the campus.

The police did not tell the Policy Group that there was a chance the gunman was loose on campus or advise the university of any immediate action that should be taken such as canceling classes or closing the university. Also, the police did not give any direction as to an emergency message to be sent to the students. The police were very busy at WAJ investigating what had happened, gathering evidence, and managing the scene. They were conveying information by phone to the Policy Group at this point. Not until 9:25 a.m. did the police have a representative sitting with the Policy Group, a police captain.

The VTPD has the authority under the Emergency Response Plan and its interpretation in practice to request that an emergency message be sent, but as related in Chapter II, the police did not have the capability to send a message themselves. That capability was in the hands of the associate vice president for University Affairs and one other official. As stated earlier, the VTPD is not a member of the Policy Group but is often invited to attend Policy Group meetings dealing with the handling of emergencies.

One of the factors prominent in the minds of the Policy Group, according to the university president and others who were present that day, was the experience gained the previous August when a convict named William Morva escaped from a nearby prison and killed a law enforcement officer and a guard at a local hospital. Police reported he might be on the VT campus. The campus administration issued an alert that a murderer was on the loose in the vicinity of the campus. Then a female employee of the bank in the Squires Student Activities Center reportedly called her mother on a cell phone, and the

mother incorrectly inferred that people were being held hostage in the student center. The mother called the police, who responded with a SWAT team. News photos of the event show students rushing out of the building with their hands up while police with drawn automatic weapons and bulletproof vests were charging into the building, a potentially dangerous situation. It was a false alarm. Morva was captured off campus, but this situation was fresh in the minds of the Policy Group as it met to decide what to do on the report of the double homicide at WAJ. It is questionable whether there was any panic among the students in the Morva incident, as some reports had it, and how dangerous that situation really was, but the Policy Group remembered it as a highly charged and dangerous situation. In the eyes of the Policy Group, including the university president, a dangerous situation had been created by their warning in that August 2006 event coupled with the subsequent spread of rumors and misinformation. The Policy Group did not want to cause a repeat of that situation if the police had a suspect and he was thought to be off campus.

Even with the police conveying the impression to campus authorities that the probable perpetrator of the dormitory killings had left campus and with the recent past history of the "panic" caused by the alert 9 months earlier, the university Policy Group still made a questionable decision. They sent out a carefully worded alert an hour and half after they heard that there was a double homicide, which was now more than 2 hours after the event.

Vice Provost of Student Affairs David Ford presented a statement to the panel on May 21, 2007. He was a member of the university Policy Group that made the decisions on what to do after hearing about the shootings.

> Shortly after 8:00 a.m. on Monday, April 16, I was informed that there had been a shooting in West Ambler Johnston hall and that President Steger was assembling the Policy Group immediately. By approximately 8:30 a.m., I and the other members of the group had arrived at the Burruss Hall Boardroom and Dr. Steger convened the meeting. I learned subsequently that as he awaited the arrival of other group members, President Steger had been in regular communication with the police, had given direction to have the governor's office notified of the shooting, and had called the head of University Relations to his office to begin planning to activate the emergency communication systems.
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> When he convened the meeting, President Steger informed the Policy Group that Virginia Tech police had received a call at approximately 7:20 a.m. on April 16, 2007, to investigate an incident in a residence hall room in West Ambler Johnston. Within minutes of the call, Virginia Tech police and Virginia Tech Rescue Squad members responded to find two gunshot victims, a male and a female, inside a room in the residence hall. Information continued to be received through frequent telephone conversations with Virginia Tech police on the scene. The Policy Group was informed that the residence hall was being secured by Virginia Tech police, and students within the hall were notified and asked to remain in their rooms for their safety. We were further informed that the room containing the gunshot victims was immediately secured for evidence collection, and Virginia Tech police began questioning hall residents and identifying potential witnesses. In the preliminary stages of the investigation, it appeared to be an isolated incident, possibly domestic in nature. The Policy Group learned that Blacksburg police and Virginia state police had been notified and were also on the scene.
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> The Policy Group was further informed by the police that they were following up on leads concerning a person of interest in relation to the shooting. During this 30-minute period of time between 8:30 and 9:00 a.m., the Policy Group processed the factual information it had in the context of many questions we asked ourselves. For instance, what information do we release without causing a panic? We learned from the Morva incident last August that speculation and misinformation spread by individuals who do not have the facts cause panic. Do we confine the information to students in West Ambler Johnston since

the information we had focused on a single incident in that building? Beyond the two gunshot victims found by police, was there a possibility that another person might be involved (i.e., a shooter), and if so, where is that person, what does that person look like, and is that person armed? At that time of the morning, when thousands are in transit, what is the most effective and efficient way to convey the information to all faculty, staff, and students? If we decided to close the campus at that point, what would be the most effective process given the openness of a campus the size of Virginia Tech? How much time do we have until the next class change?

And so with the information the Policy Group had at approximately 9 a.m., we drafted and edited a communication to be released to the university community via e-mail and to be placed on the university web site. We made the best decision we could based upon the information we had at the time. Shortly before 9:30 a.m., the Virginia Tech community—faculty, staff, and students—were notified by e-mail as follows:

"A shooting incident occurred at West Ambler Johnston earlier this morning. Police are on the scene and are investigating. The university community is urged to be cautious and are asked to contact Virginia Tech Police if you observe anything suspicious or with information on the case. Contact Virginia Tech Police at 231–6411. Stay tuned to the www.vt.edu. We will post as soon as we have more information"

The Virginia Tech Emergency/Weather Line recordings were also transmitted and a broadcast telephone message was made to campus phones. The Policy Group remained in session in order to receive additional updates about the West Ambler Johnston case and to consider further actions if appropriate.

No mention was made in the initial message sent to the students and staff of a double murder, just a shooting, which might have implied firing a gun and injuries, possibly accidental, rather than two murdered. Students and faculty were advised to be alert. The message went out to e-mails and phones. Some students and faculty saw the alert before the second event but many, if not most, did not see it, nor did most in Norris Hall classes. Those who had 9:05 a.m. classes were already in them and would not have seen the message unless checking their computers, phone, or Blackberries in class. If the message had gone out earlier, between 8:00 and 8:30 a.m., more people would have received it before leaving for their 9:05 a.m. classes. If an audible alert had been sounded, even more might have tuned in to check for an emergency message.

Few anywhere on campus seemed to have acted on the initial warning messages; no classes were canceled, and there was no unusual absenteeism. When the Norris Hall shooting started, few connected it to the first message.

The university body was not put on high alert by the actions of the university administration and was largely taken by surprise by the events that followed. Warning the students, faculty, and staff might have made a difference. Putting more people on guard could have resulted in quicker recognition of a problem or suspicious activity, quicker reporting to police, and quicker response of police. Nearly everyone at Virginia Tech is adult and capable of making decisions about potentially dangerous situations to safeguard themselves. So the earlier and clearer the warning, the more chance an individual had of surviving.

DECISION NOT TO CANCEL CLASSES OR LOCK DOWN

Many people have raised the question of whether the university should have been locked down. One needs to analyze the feasibility of doing this for a campus of 35,000 people, and what the results would have been even if feasible. Most police chiefs consulted in this review believe that a lockdown was not feasible.

When a murder takes place in a city of 35,000 population, the entire city is virtually never shut down. At most, some in the vicinity of the shooting might be alerted if it is thought that

the shooter is in the neighborhood. People might be advised by news broadcast or bullhorns to stay inside. A few blocks might be cordoned off, but not a city of 35,000. A university, however, in some ways has more control than does the mayor or police of a city, so the analogy to a city is not entirely fitting. The university is also considered by many as playing a role in *loco parentis* for at least some of its students, even those who are legally adults, a view shared by several victims' families.

President Steger noted that closing the university in an emergency presents another problem, traffic congestion. In the Morva incident, when the school was closed, it took over an hour and a half for the traffic to clear despite trying to stage the evacuation. Numerous people also stood waiting for buses. Those evacuating were very vulnerable in their cars and at bus stops.

Some people suggested that the university should have closed out of respect for the two students who were killed. However, the general practice at most large universities is not to close when a student dies, regardless of the cause (suicide, homicide, traffic accident, overdose, etc.). Universities and colleges need to make that decision based on individual criteria.

Feasibility – A building can be locked down in the sense of locking the exterior doors, barring anyone from coming or going. Elementary schools practice that regularly, and so do some intermediate and high schools. At least some schools in Blacksburg were locked down for a while after the first shootings. Usually, a lockdown also implies locking individual classrooms. Virginia Tech does not have locks on the inside of classroom doors, as is the case for most universities and many high schools.

The analogy to elementary or high schools, however, is not very useful. The threat in elementary schools usually is not from students, the classrooms have locks, they have voice communication systems to teachers and students, and the people at risk are in one building, not 131 buildings. High schools usually have one building and some of the other characteristics too.

A message could theoretically be sent to all buildings on campus to lock their doors, but there was no efficient way to do this at Virginia Tech. It would have required calls or e-mails to individuals who had the ability to lock the doors for at least 131 buildings or sending people on foot to each building. E-mails might have been used, but one could not be sure they would be read promptly. Even if people in the buildings received a message by phone or e-mail, the university had no way of knowing who received the message without follow up calls or requesting returned responses to the calls and e-mails. The process was complicated and would have taken considerable time.

Some university campuses, mostly urban ones, have guards at every entrance to their buildings. Virginia Tech does not. It would take approximately 450–500 guards to post one at all entrances of all major buildings on the VT campus.[49] The VTPD at full strength has 41 officers, of which only 14 are on-duty at 8:00 a.m. on a weekday, 5 on patrol and 9 in the office including the chief. It is unlikely all VT buildings could be guarded or closed within 1–2 hours after the first shooting.

Closing all of the roads into the school would also be a problem. The large campus includes 16 vehicle entrances separated in some cases by a mile from each other. More police can be brought in from Blacksburg and other areas. Without a clear emergency, however, it is inconceivable that large numbers of police would rush to the campus, leaving non-campus areas at risk from the same gunman and all other crimes when it was not expected to be more than an isolated incident.

There are no barriers to pedestrians walking across lawns into the campus. It would have taken hundreds of police, National Guard troops, or others to truly close down the campus, and they could not have arrived in time.

[49] There are about 30 dorm-type buildings with an average of about two entrances each, and 100 classroom/administration buildings with an average of about four entrances each, for an estimated total of about 460.

Messages might have been prioritized to reach the buildings with the most people and to guard them first, but it still was impractical and not seriously considered. All police with whom the panel consulted felt that a lockdown for a campus like Virginia Tech was not feasible on the morning of April 16.

More feasible would have been canceling classes and asking everyone to stay home or stay indoors until an all-clear was given, although even getting that message to everyone quickly was problematical with the new emergency alerting system not totally in place. Students could have been asked to return to their dormitories or to housing off campus. However, many might have gone to other public buildings on campus unless those buildings also were ordered to close. Canceling classes and getting a message out to students off campus would have stopped some from coming onto the campus. But students still could congregate vulnerably in dorms or other places.

Furthermore, the police and university did not know whether the gunman was inside or outside WAJ or other buildings. People not in buildings, typically numbering in the thousands outdoors on the campus at a given time, may seek refuge in buildings in the face of an emergency. Without knowing where the gunman is, one might be sending people into a building with the gunman, or sending them outside where a gunman is waiting. The shooters at the Jonesboro Middle School massacre in Arkansas in 1998 planned to create an alarm inside their school building and get students and faculty to go outside where the shooters were set up.

Cho, too, could have shot people in the open on campus, after an alert went out, waiting for them outside. Although he was armed with only handguns, no one knew that at the time. The Texas tower shooter sniped at people with a rifle outdoors.

Impact of Lockdown or Closedown – In this event, the shooter was a member of the campus community, an insider with a pass card to get into his dorm, able to receive whatever message was sent to the university community, and able to go anywhere that students were allowed to go. He would have received an alert, too.

It might be argued that the total toll would have been less if the university had canceled classes and announced it was closed for business immediately after the first shooting; or if the earlier alert message had been stronger and clearer. Even with the messaging system that was in place on April 16, many could have received messages before they left for class by e-mail or phone before 9 a.m., and the message probably would have quickly spread mouth to mouth as well. Even if it only partially reduced the university population on campus, it might have done some good. It is the panel's judgment that, all things considered, the toll could have been reduced had these actions been taken. But none of these measures would likely have averted a mass shooting altogether. There is a possibility that the additional measures would have dissuaded Cho from acting further, but he had already killed two people and sent a tape to NBC that would arrive the following morning with all but a confession. From what we know of his mental state and commitment to action that day, it was likely that he would have acted out his fantasy somewhere on campus or outside it that same day.

This was a single-shooter scenario; Columbine High School had two shooters, and that scenario was quite different. Emergency planners have to anticipate various high-risk scenarios and how to prepare for them. They must be aware that what happens will rarely be just like the scenario planned for. The right thing for one scenario might be just the wrong thing to do for another, such as whether to tell people to stay inside buildings or get outside.

CONTINUING EVENTS

To continue the story of April 16, there was not an event, a pause for 2 hours, and then a second event. The notion that there was a 2-hour gap as mentioned in some news stories and by many who sent questions to the panel is a

misconception. There was continuous action and deliberations from the first event until the second, and they made a material difference in the results of the second event.

Police Actions – The VTPD and the other law enforcement agencies involved did a professional job in pursuing the investigation of the WAJ incident with the one large and unfortunate exception of having conveyed the impression to the university administration that they probably had a solid suspect who probably had left the campus. These agencies did not know that with certainty. A stronger patrol of the campus and random checking of bags being carried might have found Cho carrying guns. Cho, however, was one of tens of thousands of students on campus, did not stand out in appearance, and carried his weapons in a backpack like many other backpacks. The police had no clues pointing to anyone other than the boyfriend, and it would not have been reasonable to expect them to be able to check what each person on campus was carrying.

The VTPD and BPD mobilized their emergency response teams after the first shooting. They did not know what the followup would bring, but they wanted to be ready for whatever occurred. The VTPD had not investigated a homicide in recent memory, and properly called on the resources of the BPD, state police, and ultimately ATF and FBI to assist in the investigation.

Boyfriend Questioning – At 9:30 a.m., the boyfriend of Emily Hilscher was stopped in his pickup truck on a road. He was cooperative and shocked to hear that his girlfriend had just been killed. He passed a field test for the presence of gunpowder residue. While he remained a person of interest, it appeared unlikely that he was the shooter, with the implication that the real shooter was probably still at large. The police passed this information to the university leadership through the police captain who was interacting with the university staff.

This negative finding on the boyfriend raised the urgency of the situation, and the university proceeded to send out more alerts of the changing situation, but by then it was too late.

Even after they realized he was not a likely suspect and had been traumatized by the news of his girlfriend's death, the police agencies involved in stopping and questioning Emily Hilscher's boyfriend did not treat him sympathetically; he deserved better care.

Cho's Next Actions – After shooting the two students in WAJ, Cho went back to his own dormitory, arriving at 7:17 a.m. (based on the record of his swipe card). He changed out of his blood-stained clothing, which was later found in his room. He accessed his university computer account at 7:25 a.m. and proceeded to delete his e-mails and wipe out his account. He then removed the hard drive of his computer and later disposed of it and his cell phone. Cho apparently also had planned to dispose of his weapons after using them in a different scenario because he had filed down the serial numbers on the guns.[50] Mentally disturbed killers often make one plan and then change it for some reason. The motivation may never be known for why he partially obscured his identity and did not carry any identification into Norris Hall, but then sent his manifesto to a national news network with his pictures.

Between 8:10 and 8:20 a.m., an Asian male thought now to be Cho was seen at the Duck Pond. (The pond has been searched unsuccessfully for the whereabouts of his phone and hard drive, which are still missing.)

Before 9:00 a.m., Cho went to the Blacksburg post office off campus, where he was recognized by a professor who thought he looked frightening. At 9:01 a.m., he mailed a package to NBC News in New York and a letter to the university's English Department.

Diatribe – The panel was allowed to view the material Cho sent to NBC. The package was signed "A. Ishmael," similar to the "Ax Ishmael"

[50] The ATF laboratory was able to raise the numbers and identify the weapons collected after the shootings.

name he had written on his arm in ink at the time he committed suicide and also the name he used to sign some e-mails. The significance of this name remains to be explained, but it may tie to his self-view as a member of the oppressed.

Inside the package was a CD with a group of about 20 videos of himself presenting his extreme complaints against the world, two rambling, single-spaced letters with much the same information that were used as the scripts for the videos, and pictures of himself with written captions. The pictures showed him wielding weapons, showing his preparations for a mass murder, and railing against society that had ill-treated him. He seemed to be trying to look powerful posing with weapons, the "avenger" for the mistreated and downtrodden of the world, and even its "savior", in his words.

The videos and pictures in the package appear to have been taken at various times in a motel, a rented van, and possibly his dorm room over the previous weeks. It is likely that he alone took the photos; he can be seen adjusting the camera.

His words to the camera were more than most people had ever heard from him. He wanted his motivation to be known, though it comes across as largely incoherent, and it is unclear as to exactly why he felt such strong animosity. His diatribe is filled with biblical and literary references and references to international figures, but in a largely stream of consciousness manner. He mentions no one he knew in the videos. Rather, he portrays a grandiose fantasy of becoming a significant figure through the mass killing, not unlike American assassins of presidents and public figures. The videos are a dramatic reading or "performance" of the writings he enclosed. He read them several minutes at a time, then reached up to turn off the camera, changed the script he had mounted near the camera, and continued again. They clearly were not extemporaneous.[51] Intentionally or accidentally, he even provided two takes of reading one portion of his written diatribe.

After the mailings, Cho's exact path is unknown until he gets to Norris Hall.

MOTIVATION FOR FIRST KILLINGS?

No one knows why Cho committed the first killings in the dormitory. He ran a great risk of being seen and having any of a number of things go wrong that could have thwarted his larger plan. One line of speculation is that he might have been practicing for the later killings, since he had never shot anyone before (some serial killers have been known to do this). He may have thought he would create a diversion to draw police away from where his main action would later be, though in fact it worked the opposite way. Many more police were on campus than would have been there without the first shootings, which allowed the response to the second incident to be much faster and in greater force. There is also a possibility that he considered attacking a woman as part of his revenge—he was known to have stalked at least three women in the previous year and had complaints registered against him, one from WAJ. Although there is a small possibility he knew the victim, no evidence of any connection has been found. In fact, he did not really know any of his victims that day, not faculty, roommates, or classmates. None of the speculative theories as to motive seem likely. The state and campus police have not closed their cases yet, in part trying to determine his motives.

KEY FINDINGS

Generally the VTPD and BPD officers responded to and carried out their investigative duties in a professional manner in

[51] NBC News in New York has the package Cho sent to them and has released only a small amount of the material. There is a balance between the public interest and the harm this material can do to families of victims, the potential for giving incentive to future shooters, and the possibility of hidden messages triggering actions of others. NBC spent much time wrestling with what was the responsible thing to do journalistically. It was a difficult set of decisions. They did not delay at all in getting the information package to the FBI well before they released any of it.

accordance with accepted police practices. However, the police conveyed the wrong impression to the university Policy Group about the lead they had and the likelihood that the suspect was no longer on campus.

The police did not have the capability to use the university alerting system to send a warning to the students, staff, and faculty. That is, they were not given the keyword to operate the alerting system themselves, but rather they had to request a message be sent from the Policy Group or at least the associate vice president for University Relations, who did have the keyword. The police did have the authority to request that a message be sent, but did not request that be done. They gave the university administration the information on the incident, and left it to the Policy Group to handle the messaging.

The university administration failed to notify students and staff of a dangerous situation in a timely manner. The first message sent by the university to students could have been sent at least an hour earlier and been more specific. The university could have notified the Virginia Tech community that two homicides of students had occurred and that the shooter was unknown and still at large. The administration could have advised students and staff to safeguard themselves by staying in residences or other safe places until further notice. They could have advised those not en route to school to stay home, though after 8 a.m. most employees would have been en route to their campus jobs and might not have received the messages in time.

Despite the above findings, there does not seem to be a plausible scenario of university response to the double homicide that could have prevented a tragedy of considerable magnitude on April 16. Cho had started on a mission of fulfilling a fantasy of revenge. He had mailed a package to NBC identifying himself and his rationale and so was committed to act that same day. He could not wait beyond the end of the day or the first classes in the morning. There were many areas to which he could have gone to cause harm.

RECOMMENDATIONS

VII-1 In the preliminary stages of an investigation, the police should resist focusing on a single theory and communicating that to decision makers.

VII-2 All key facts should be included in an alerting message, and it should be disseminated as quickly as possible, with explicit information.

VII-3 Recipients of emergency messages should be urged to inform others.

VII-4 Universities should have multiple communication systems, including some not dependent on high technology. Do not assume that 21st century communications may survive an attack or natural disaster or power failure.

VII-5 Plans for canceling classes or closing the campus should be included in the university's emergency operations plan. It is not certain that canceling classes and stopping work would have decreased the number of casualties at Virginia Tech on April 16, but those actions may have done so. Lockdowns or cancellation of classes should be considered on campuses where it is feasible to do so rapidly.

ADDITIONS AND CORRECTIONS

Cho's Access to WAJ: p. 77, Clarification and Addition – Cho had access to his mailbox in the foyer of West Ambler Johnston residence hall, but only after 7:30 a.m. Cho did not have key access to the rest of the residence hall. At about 6:45 a.m. he was seen loitering in the foyer area, between the exterior and interior doors. He may have entered the foyer and then the interior residential area when other students entered or exited, but no one remembered facilitating his entry.

Motive for Homicides: p. 77, Addition – As of October 2009 no motive has been established for the double homicide at WAJ. There have been speculations that it was a rehearsal and test of nerve for the later actions, or a diversion, but the risk of being caught before committing the mass murders was high. There was no mention in Cho's writings or videotapes that suggested a motive or link to the victims at WAJ. Cho had harassed a female student on the same floor as Emily Hilscher, but neither Emily's roommate nor anyone else interviewed knew of any connection between Emily and Cho.

Time of Shootings: p. 78, Addition – The exact time of the double shooting is not known. The Report stated "not long after 7:15 a.m." Emily Hilscher had swiped her card upon entry to WAJ at 7:02 a.m. and Cho swiped his entry card back at his dorm at 7:17 a.m. So Hilscher and Clark were shot sometime between a few minutes after 7:02 and a few minutes before 7:17 a.m., depending on the path and speed of Hilscher as she went to her room, the interaction in her room, and the path and speed of Cho as he returned to his room after the murders. The first call to police was at 7:20 a.m., approximately 5 minutes after the shooting, after two students had discussed whether to report the noise they heard.

Failure of Timely Notice to Emily Hilscher's Family: p. 78, Addition – No one from Virginia Tech or from the hospitals contacted the Hilscher family before she died to let them know Emily had been shot and was severely wounded. The VTPD knew Emily's identity from information provided by Heather Haugh, Emily Hilscher's roommate, around 8:15 a.m. The Hilschers learned their daughter was a victim from the mother of Emily's boyfriend, Karl Thornhill, and the Thornhills did not know where Emily had been taken. The Hilschers exerted every effort to locate Emily but ran into problems with hospital personnel not wanting to disclose information over the phone. The family lived about a 3 ½ hour drive from campus, but had the family received a timely call and been told where Emily was being treated they would have had a chance to at least place a call and talk to Emily's doctors and to her even if she could not respond. Moreover, the Hilschers would not have had to go through the stress of not knowing Emily's condition. Notification of family should have been an immediate priority and should have been verified as having been performed by the Virginia Tech administrators, VTPD, and/or Virginia State Police.

Additional Officials at WAJ: pp. 78–79, Addition – Dr. Spencer, Associate VP for Student Affairs, arrived at WAJ at 7:55 a.m., and then called the VP for Student Affairs, Dr. Zenobia Hikes with information on the events.

Emily's Roommate: p. 79, Addition – The "girlfriend" of Emily Hilscher who was interviewed by the police was Emily's roommate, Heather Haugh. The boyfriend of Emily referred to in the text was Karl Thornhill. (The review panel chose to minimize use of student names to focus on the lessons learned, and maintain privacy, but some victims' families have asked that these names be noted.)

Time of Roommate Interview: p. 79, Addition – Emily's roommate Heather Haugh swiped her card at WAJ at 8:14 a.m. and was then interviewed by the police. (She was interviewed inside the residence, so the interview time was after 8:14.) Police did not know about Emily's boyfriend until that point. Immediately following the interview he became a "person of interest." The Policy Group did not know this fact until police updated them at 8:40 a.m. Until then the Policy Group just knew there was a double shooting with both student victims critically wounded, the shooter was unknown and at large, and that the initial police impression was that it was probably a domestic issue.

Lockdown of WAJ: p. 79, Addition – Police in effect locked down WAJ residence hall after the shootings to process the crime scene and interview witnesses. Police were inside and outside the residence hall. No one was allowed to leave. The shooter was unknown and possibly still present. Some time before 9:00 a.m. students in the dorm were allowed to exit and go to class. Tragically, two of them were later killed during the mass shootings at Norris Hall. As was normally the case, doors on all dormitories remained locked and required a resident's scan card to get in until 10:00 a.m.

Solution to Initial Homicides: p. 79, Clarification – The Report states: "If Cho had stopped after the first two shootings, he might well have never been caught." That was the opinion of VTPD Chief Flinchum reflecting on the paucity of evidence. There were shell casings, which could help identify a gun once it was found, and bloody footprints, which could help identify a shoe, but the gun and shoe had to be found and linked to a suspect. As a side note, at least three states at the time, including Maryland and New York, required gun dealers to test-fire each gun sold and send the results to the state, which maintained a registry and database of this information. The gun purchaser could be identified from a shell casing found at a crime scene. California went further, and required guns to have a chip inserted that marked each casing with an identification number by which a gun purchaser could be rapidly identified. In those states it is likely that the registered owner of the gun used in the shooting would have been identified even if no other evidence were found.

Victim Still Alive: p. 79, Correction – When the Policy Group was first informed about the shootings, Emily Hilscher was still alive. The Report should not have referred to both victims as homicides at that point in time. Emily survived for three hours while she was treated at two hospitals.

Chief Flinchum Calls to BPD and Executive Vice President: p. 80, Clarification – The Report stated Chief Flinchum was notified about the shootings at 7:40 a.m. and then contacted Blacksburg PD. The latter occurred at 7:51 a.m. He also tried to reach the Office of the Executive Vice President but did not get through until 7:57 a.m.

Delayed Alert: pp. 80-81, Correction and Addition – President Steger first spoke directly with Virginia Tech Police Chief Flinchum at 8:11 a.m., and then convened the Policy Group, which met at 8:25 am. According to a police briefing for victims' families, Chief Flinchum told President Steger that two students were critically wounded, that no weapon was found, that there were bloody footprints, and that the incident seemed to be domestic in nature. Chief Flinchum did not offer a recommendation about an alert or closing the campus at that time nor was he asked his opinion about doing so. Essentially, the police focused on the investigation and hunt for the killer, and the Policy Group was left to handle the alert.

The Review Panel had been told that the Policy Group was informed early on that there was a person of interest. However, the first calls to the Policy Group and President could not have mentioned a person of interest because it was not until at least a few minutes after the 8:14 A.M arrival of Emily Hilscher's roommate at WAJ that the police learned of Emily's boyfriend and that he owned a gun.

Under the provisions of Virginia Tech's policy document called "Campus Safety: A Shared Responsibility," the VTPD is given the responsibility and authority to send an emergency alert. That document, formulated as part of Virginia Tech's compliance with the Clery Act, required issuing a timely warning. It stated in pertinent part:

i. *(Page 1) "Virginia Tech has designed policies and regulations in order to create a safer and more harmonious environment for the members of its community. All campus community members and visitors of the university are required to obey these regulations. These policies not only reflect the university's high standards of conduct, but also local, state and federal laws. Observed and enforced, they create a high degree of safety for the university community."*

ii. *(Page 6) "At time it may be necessary for "timely warnings" to be issued to the university community. If a crime(s) occur [sic] and notification is necessary to warn the University of a potential[sic] dangerous situation then the Virginia Tech Police Department should be notified. The police department will then prepare a release and the information will be disseminated to all students, faculty and staff and to the local community."*

However, Virginia Tech's Emergency Management Plan also contained formal emergency alert procedures and these assigned authority for releasing a warning to the Policy Group only. The two documents and policies were inconsistent. The one that VTPD and the Policy Group followed on April 16th was the Emergency Management Plan because that Plan was the one with which they were familiar and historically had used as their basis of operations. Under the Emergency Management Plan, the VTPD could request or develop, but not send, an alert because they did not have the computer code needed to send out a warning. Only two Virginia Tech officials had the code, and the police chief was not one of them. The code was needed to ensure that any message was authorized, and was not a false alarm – which had occurred previously in some messages to the local media.

Pre-Alert Actions to Protect: p. 83, Addition – The Report stated that few on campus acted on the first warning message sent, and that still appears to be generally correct. However, there were a growing number of actions taken even before the first official warning message from Virginia Tech was sent, as word of the shootings spread by word of mouth and media and other means. Some people who had information about the double shooting acted to protect their safety and the safety of others for whom they had responsibility, even before receiving an "official" message. For example, the Center for Professional and Continuing Education, and the Veterinary College, locked down on their own accord. The VT Governmental Affairs Director ordered the President's office to be locked. VTPD cancelled bank deposit pickups and trash collection. The Blacksburg schools also made the decision to lock down.

Field Test for Gunpowder Residue: p. 86, Correction – The Report said that Emily Hilscher's boyfriend had passed a gunpowder residue test when he was stopped on the road. In fact, Thornhill was given the Primer Residue Test, but unlike some other gunpowder tests this one does not give a preliminary result in the field. Rather, the sample requires analysis in a crime lab. The sample was packaged for submission to a lab but the analysis was never done as events overtook the need to do so.

The Report also said that information on the results of the gunpowder test was passed on to the Policy Group. Since no analysis was performed no results could have been provided to the Policy Group. The Policy Group was informed of the roadside stop and test. Thus at no time on April 16 did the Policy Group have information that the person of interest was cleared for the initial double shooting. Police doubted Thornhill was a suspect after interviewing him, but he was kept as a person of interest until the next day.

When stopped by the police, Thornhill was only told that his girlfriend Emily Hilscher was shot, not that she was severely wounded. He did not know whether she was in a hospital or anything else about her situation. Police left him immediately upon receiving word about the Norris Hall attack, and Thornhill continued searching for Emily.

Search of Thornhill Apartment: p. 86, Correction and Addition – In the evening of the shooting, a police ERT (SWAT team) entered the residence of Karl Thornhill, Emily Hilscher's boyfriend. They handcuffed him and put him on the floor while they searched his apartment. They also handcuffed and put on the floor his family members who had arrived to console him. The police had a search warrant, but did not present it until they were leaving. Thornhill and his family were cooperative but felt they had been treated with a heavy hand unnecessarily, especially since police had released Thornhill after the traffic stop that morning, and did not bring him in for questioning later in the day. They did not realize he was still considered a suspect. However, it should be noted that the link between the double shooting and the mass shooting had not yet been proven, and police knew Thornhill had a gun, so they were exercising caution in the interest of everyone's safety, even though unpleasant and traumatic for the Thornhill family.

Comments of Senior VT Staff to Their Families: Addition – At about 8:15 a.m. two senior officials at Virginia Tech had conversations with family members in which the shooting on campus was mentioned. In one conversation, by phone, the official advised her son, a student at Virginia Tech, to go to class. In the other, in person, the official arranged for extended babysitting because she knew she would be tied up for more of the day as a result of the shootings.

OTHER COMMENTS

Page 81 of the Report discusses reasons why Virginia Tech delayed sending an alert. One family member commented that police informed families in a 2009 briefing that another reason for not immediately informing the campus was to avoid making the police work and investigation more difficult. Police Chief Flinchum has denied making this remark and it may or may not have been made by others or correctly understood. Nevertheless, there are indeed tradeoffs between informing a community of what has happened so they have context in which to take actions for their own safety, and possibly informing the perpetrator(s) of police knowledge and action, potentially making the investigation more difficult. The consensus of the Review Panel and many others in hindsight was that early warning should have received the higher priority

in this situation. With the events at Virginia Tech as an example, early warning with the known facts now is the widely adopted practice in numerous colleges and universities as well as other venues.

Page 87 of the Report contains a discussion of what might have happened had there been earlier warning sent to Virginia Tech students and staff about a shooter on the loose. The Report spoke of Cho "fulfilling a fantasy of revenge" which he had articulated in the videos he sent to NBC and that it was likely he would have found some variation on his plan, since he had already essentially committed himself by mailing the videotaped message at 9:00 a.m. and was probably of a mind to complete his "mission." The question was asked by a victim family member: what would have resulted if the warning went out prior to 9:00 a.m., and Cho heard about or saw evidence of a manhunt and preventive measures such as additional police patrols, buildings being locked down, etc. before he sent out the videos? Might he have not sent the tape and aborted his "mission?"

There are many "what if" questions that can be raised, and no one knows the answers for certain. The forensic psychologist on the Review Panel thought that most likely Cho was committed to his mission: he had purchased and trained with his weapons, had obtained chains for the doors and rehearsed using them, and had thought out the scenario. When Cho returned to his dorm room, he erased his hard drive and deleted his Virginia Tech account, a sign he was starting a departure process. If not implementing his scheme as originally planned, he could have staged a variation that day in a residence hall, dining hall, or out in the open, or waited another day.

Another family member asked why the Virginia Tech Emergency Plan was not updated after the Morva incident the previous year, in which the gunman was (incorrectly) thought to be on campus. Though the plan was not revised, and no annex written specifically for handling a shooting incident or a shooter loose on campus, some major changes in preparedness were in process. The whole emergency alerting system was being upgraded significantly at the time of the April 16, 2007 incidents. The police departments in the region practiced how to handle a shooting incident. The VT Rescue Squad practiced handling mass casualty incidents. These police and EMS preparations undoubtedly saved lives on April 16.

A third question was why Virginia Tech did not conduct exercises for sending out an alert. Virginia Tech sent actual alerts for weather emergencies and other events from time to time, and was testing parts of the new emergency response system as they came on-line. Once the system was completed, it was tested again.

Chapter VIII.
MASS MURDER AT NORRIS HALL

Many police were on campus in the 2 hours following the first incident, most at West Ambler Johnston residence hall but others at a command center established for the first incident. Two emergency response teams (ERTs) were positioned at the Blacksburg Police Department (BPD) headquarters, and a police captain was with the Virginia Tech Policy Group acting as liaison.

Cho left the post office about 9:01 a.m. (the time on his mailing receipt). He proceeded to Norris Hall wearing a backpack with his killing tools. He carried two handguns, almost 400 rounds of ammunition most of which were in rapid loading magazines, a knife, heavy chains, and a hammer. He wore a light coat to cover his shooting vest. He was not noticed as being a threat or peculiar enough for anyone to report him before the shooting started.

In Norris Hall, Cho chained shut the pair of doors at each of the three main entrances used by students. Figure 7 shows one such entrance. The chaining had the dual effect of delaying anyone from interrupting his plan and keeping victims from escaping. After the Norris Hall incident, it was reported to police that an Asian male wearing a hooded garment was seen in the vicinity of a chained door at Norris Hall 2 days before the shootings, and it may well have been Cho practicing. Cho may have been influenced by the two Columbine High School killers, whom he mentioned in his ranting document sent to NBC News and previously in his middle school writings. He referred to them by their first names and clearly was familiar with how they had carried out their scheme.

On the morning of April 16, Cho put a note on the inside of one set of chained doors warning that a bomb would go off if anyone tried to remove the chains. The note was seen by a faculty member, who carried it to the Engineering

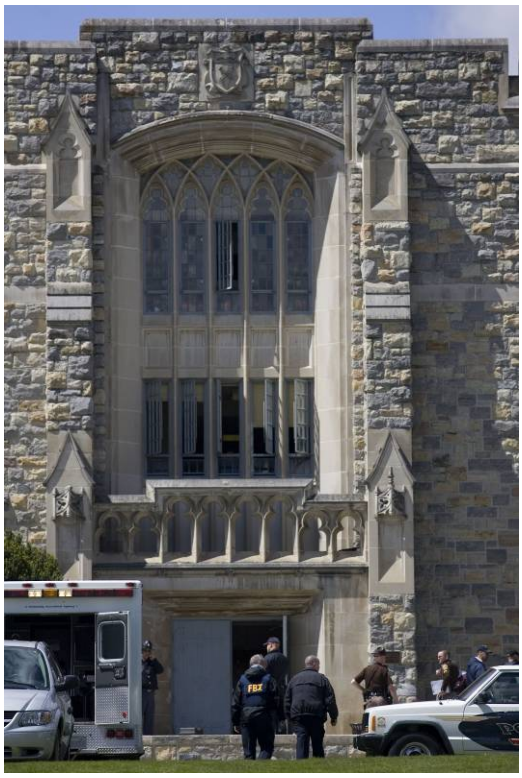

Figure 7. One of the Main Entrances to Norris Hall

School dean's office on the third floor. This was contrary to university instructions to immediately call the police when a bomb threat is found. A person in the dean's office was about to call the police about the bomb threat when the shooting started. A handwriting comparison revealed that Cho wrote this note, but that he had not written bomb threat notes found over the previous weeks in three other buildings. Those threats, which led to the evacuation of the three buildings, proved to be false. That may have contributed to the Cho note not being taken seriously, even though found on a chained door.

The usual VTPD protocol for a bomb threat that is potentially real is to send officers to the threatened building and evacuate it. Had the Cho bomb threat note been promptly reported prior to the

start of the shooting, the police might have arrived at the building sooner than they did.

A female student trying to get into Norris Hall shortly before the shooting started found the entrance chained. She climbed through a window to get where she was going on the first floor. She did not report the chains, assuming they had something to do with ongoing construction. Other students leaving early from an accounting exam on the third floor also saw the doors chained before the shooting started, but no one called the police or reported it to the university.

Prior to starting the shootings, Cho walked around in the hallway on the second floor poking his head into a few classrooms, some more than once, according to interviews by the police and panel. This struck some who saw him as odd because it was late in the semester for a student to be lost. But no one raised an alarm. Figure 8 shows the hallway in Norris Hall.

Figure 8. Hallway in Norris Hall

THE SHOOTINGS

The occupants of the first classroom that Cho attacked had little chance to call for help or take cover. After peering into several classrooms, Cho walked into the Advanced Hydrology engineering class of Professor G. V. Loganathan in room 206, shot and killed the instructor, and continued shooting, saying not a word. In fact, he never uttered a sound during his entire shooting spree—no invectives, no rationale, no comments, nothing. Even during this extreme situation at the end of his life, he did not speak to anyone. Of 13 students present in the classroom, 9 were killed and 2 injured by shooting, and only 2 survived unharmed. No one in room 206 was able to call the police.

Occupants of neighboring classrooms heard the gunshots but did not immediately recognize them as gunfire. One student went into the hallway to investigate, saw what was happening, and returned to alert the class.

First Alarm to 9-1-1 – Cho started shooting at about 9:40 a.m. It took about a minute for students and faculty in room 211, a French class, to recognize that the sounds they heard in the nearby room were gunshots. Then the instructor, Jocelyne Couture-Nowak, asked student Colin Goddard to call 9-l-l.

Cell phone 9-1-1 calls are routed according to which tower receives them. Goddard's call was routed to the Blacksburg police. Another call by cell phone from room 211 was routed first to the Montgomery County sheriff. The call-taker at the BPD received the call at 9:41 a.m. and was not familiar with campus building names. But it took less than a minute to sort out that the call was coming from Virginia Tech and it was then transferred to the Virginia Tech Police Department (VTPD).

At 9:42 a.m., the first call reached the Virginia Tech police that there was shooting in Norris Hall. Other calls later came from other classrooms and offices in Norris Hall and from other buildings.

Students and faculty in other nearby rooms also heard the first shots, but no one immediately realized what they were. Some thought they were construction noises. Others thought they could be the popping sounds sometimes heard from chemistry lab experiments on the first floor. One professor told his class to continue with the lesson after some raised questions about the noise. When the noise did not stop, some people went into the hallway to investigate. One student from an engineering class was shot when he

entered the hallway. At that point, terror set in among the persons in the classrooms who realized that what they were hearing was gunfire.

Continued Shooting – This section portrays the sense of the key action rather than trace the exact path of Cho. It is based on police presentations to the panel, police news releases, and interviews conducted by the panel.

After killing Professor Loganathan and several students in room 206, Cho went across the hall to room 207, a German class taught by Christopher James Bishop. Cho shot Professor Bishop and several students near the door. He then started down the aisle shooting others. Four students and Bishop ultimately died in this room, with another six wounded by gunshot. One student tried to wrench free the podium that was fastened securely to the floor in order to build a barricade at the door. She was unsuccessful and injured herself in the process.

As Goddard called 9-1-1 from classroom 211, Couture-Nowak's class tried to use the instructor's table to barricade the door, but Cho pushed his way in, shot the professor, and walked down the aisle shooting students. Cho did not say anything. Goddard was among the first to be shot. Another student, Emily Haas, picked up Goddard's cell phone after he was shot. She stayed on the line for the rest of the shooting period. She was slightly wounded twice in the head by bullets, spoke quietly as long as she could to the dispatcher, heard that the police were responding, closed her eyes, and played dead. She said she did not open her eyes again for over 10 minutes until the police arrived. During her ordeal, she was concerned that the shooter would hear the 9-1-1 dispatch operator over the cell phone. But by keeping the line open she helped keep police apprised of the situation. She kept the phone hidden by her head and hair so she could appear dead but not disconnect. Although the dispatcher at times asked her questions and at other times told her to keep quiet, she spoke only when Cho was out of the room, which she could tell by the proximity of the shots.

Students in room 205 attending a class in scientific computing heard Cho's gunshots and barricaded the door to prevent his entry, mainly with their bodies kept low, holding the door with their feet. Cho never did succeed in getting into this room though he pushed and fired through the door several times. No one was injured by gunshot in this room.

Back in room 207, the German class, two uninjured students and two injured students rushed to the door to hold it shut with their feet and hands before Cho returned, keeping their bodies low and away from the center of the door. Within 2 minutes, Cho returned and beat on the door. He opened it an inch and fired about five shots around the door handle, then gave up trying to reenter and left.

Cho returned to room 211, the French class, and went around the room, up one aisle and down another, shooting students again. Cho shot Goddard two more times. Goddard lay still and played dead. This classroom received the most visits by Cho, who ultimately killed 11 students and the instructor, and wounded another 6, the entire class. A janitor saw Cho reloading his gun in the hall on the second floor and fled downstairs.

Cho tried to enter the classroom of engineering professor Liviu Librescu (room 204), who was teaching solid mechanics. Librescu braced his body against the door and yelled for students to head for the window. Students pushed out the screens and jumped or dropped onto bushes or the grassy ground below the window. Ten of the 16 students escaped this way. The next two students trying to leave through the window were shot. Librescu was fatally shot through the door trying to hold it closed while his students escaped. A total of four students were shot in this class, one fatally.

Cho returned to most of the classrooms more than once to continue shooting. He methodically fired from inside the doorways of the classrooms, and sometimes walked around inside them. It was very close range. Students had little place to

hide other than behind the desks. By taking a few paces inside he could shoot almost anyone in the classroom who was not behind a piece of overturned furniture. The classrooms were all roughly square, with no obstructions. Figure 9 shows the interior of a typical classroom, seen from the corner furthest from the door. Table 1 shows the dimensions of the rooms with the shootings.

Figure 9: Interior of Typical Classroom

Table 1. Dimensions of the Classrooms Attacked

Room #	Dimensions
204	28' x 25'
205	24' x 25'
206	22' x 25'
207	24' x 25'
211	22' x 25'

The rooms were furnished with lightweight desk–chair combinations, single units combining both functions. Each instructor had a table desk and a podium, the latter bolted to the floor. The doors were not lockable from the inside. Unlike many lower grade schools and typical of most colleges, the instructors had no university-furnished messaging system for receiving or sending an alarm. Emergency communications from classrooms were limited to any phone or electronic devices carried by students or instructors. The offices had standard telephones, but they were on the third floor.

The massacre continued for 9 minutes after the first 9-1-1 call was received by the VTPD, and about 10–12 minutes in total, including a minute for processing and transferring the call to VTPD, and the time to comprehend that shots were being fired and to make the call. From the first call, shots can be heard continuously on the dispatch tapes, until they stopped with the suicide shot.

Within that period, Cho murdered 25 students and 5 faculty of Virginia Tech at Norris Hall. Another 17 were shot and survived, and 6 were injured when they jumped from classroom windows to escape.

Cho expended at least 174 bullets from two semiautomatic guns, his 9mm Glock and .22 caliber Walther, firing often at point-blank range. The police found 17 empty magazines, each capable of holding 10–15 bullets. Ammunition recovered included 203 live cartridges,122 for the Glock and 81 for the Walther. The unexpended ammunition included two loaded 9mm magazines with 15 cartridges each and many loose bullets.

Cho committed suicide by shooting himself in the head, probably because he saw and heard the police closing in on him. With over 200 rounds left, more than half his ammunition, he almost surely would have continued to kill more of the wounded as he had been doing, and possibly others in the building had not the police arrived so quickly. Terrible as it was, the toll could have been even higher.

DEFENSIVE ACTIONS

According to survivors, the first reaction of the students and faculty was disbelief, followed rapidly by many sensible and often heroic actions. One affirmative judgment in reflecting on this event is that virtually no one acted irrationally. People chose what they thought was the best option for their survival or to protect others, and many tried to prevent the shooter from gaining access to their room. Unfortunately, a shooter operating at point-blank range does not offer many options.

Escaping – Professor Librescu's class was the only one where students escaped by jumping from windows. This classroom's windows face a grassy area. (Figure 10 is the view from outside and Figure 11 shows the structure of the windows. The view from inside looking out is shown in Figure 12.)

Figure 10. Norris Hall Classroom Windows, Grassy Side

Figure 11. Typical Set of Windows in Norris Hall

Figure 12. To Escape, They Had to Climb Over the Low Window

The window sills are 19 feet high from the ground, two stories up. In order to escape through the window, the first jumper, a male student, had to take down a screen, swing the upper window outward, climb over the lower portion of the window that opened into the classroom, and then jump. He tried to land on the bushes. Following his example, most of the rest of the class formed groups behind three windows and started jumping. All who jumped survived, some with broken bones, some uninjured except for scratches or bruises. Some survivors did the optimum window escape, lowering themselves from the window sill to drop to the ground, reducing the fall by their body length.

The other classes faced out onto concrete walks or yards, and jumping either did not seem a good idea or perhaps did not even enter their minds. No one attempted to jump from any other classroom.

Some attempts were made by a few students to escape out of the classroom and down the hall in the earliest stage of the incident. But after some people were shot in the hall, no one else tried that route.

Attempting to Barricade – In three of the four classrooms that Cho invaded and one more that resisted invasion, the instructor and students attempted to barricade the door against Cho entering either on his first attempt or on a later try. They tried to use the few things available— the teacher's table, the desk–chair combinations, and their bodies. Some attempts to barricade succeeded and others did not. Cho pushed his way in or shot through some doors that were being barricaded. In the German class, two wounded students and two non-wounded students managed to hold the door closed against the return entry by Cho. They succeeded in staying out of the line of fire through the door. Two other rooms did the same. In one, Cho never did get in. At least one effort was made to use the podium, but it failed (it was bolted to the floor). Cho was not a strong person—his autopsy noted weak musculature—and these brave students and faculty helped reduce the toll.

Playing Dead – Several students, some of whom were injured and others not, successfully played dead amid the carnage around them, and survived. Generally, they fell to the ground as shots were fired, and tried not to move, hoping Cho would not notice them. Cho had systematically shot several of his victims a second time when he saw them still alive on revisiting some of the rooms, so the survivors tried to hold still and keep quiet. This worked for at least some students.

POLICE RESPONSE

Within 3 minutes of the Virginia Tech police receiving the 9-1-1 call, two officers arrived outside of Norris Hall by squad car. They were Virginia Tech officer H. Dean Lucas and Blacksburg Sgt. Anthony Wilson. A few seconds later, three more officers arrived by car: Blacksburg Police Department officers John Glass, Scott Craig, and Brian Roe. More continued to arrive throughout the incident.

By professional standards, this was an extraordinarily fast police response. The officers had been near WAJ as part of the investigation and security following the first incident, so they were able to respond much faster than they otherwise would have. The two police forces trusted each other, had trained together, and did not have to take time sorting out who would go from which organization in which car. They just went together as fast as they could.

The five officers immediately proceeded to implement their training for dealing with an active shooter. The policy is to go to the gunfire as fast as possible, not in a careless headlong rush, but in a speedy but careful advance. The first arriving officers had to pause several seconds after exiting their cars to see where the gunfire was coming from, especially whether it was being directed toward them. They quickly figured out that the firing was inside the building, not coming from the windows to the outside. Because Cho was using two different caliber weapons whose sounds are different, the assumption had to be made that there was more than one shooter.

The officers tried the nearest entrance to Norris Hall, found it chained, quickly proceeded to a second and then a third entrance, both also chained. Attempts to shoot off the padlocks or chains failed. They then moved rapidly to a fourth entrance—a maintenance shop door that was locked but not chained. They shot open the conventional key lock with a shotgun. Five police officers entered and rapidly moved up the stairs toward the gunfire, not knowing who or how many gunmen were shooting.

The first team of five officers to enter Norris Hall after the door lock was shot were:

VT Officer H. Dean Lucas (patrol)
Blacksburg Officer Greg Evans (patrol)
Blacksburg Officer Scott Craig (SWAT)
Blacksburg Officer Brian Roe (SWAT)
Blacksburg Officer Johnny Self (patrol)

They were followed seconds later by a second team of seven officers:

VT Lt. Curtis Cook (SWAT)
VT Sgt Tom Gallemore (SWAT)
VT Sgt Sean Smith (SWAT)
VT Officer Larry Wooddell (SWAT)
VT Officer Keith Weaver (patrol)
VT Officer Daniel Hardy (SWAT)
Blacksburg Officer Jeff Robinson (SWAT)

Both teams had members from more than one police department. The first police team got to the second floor hallway leading to the classrooms as the shooting stopped. The second police team that entered went upstairs to the opposite end of the shooting hallway on the second floor. They saw the first team at the opposite end of the hall and held in place to avoid a crossfire should the shooter emerge from a room. They then went to clear the third floor.

The first team of officers arriving on the second floor found it eerily quiet. They approached cautiously in the direction from which the shots were fired. They had to clear each classroom and office as they passed it lest they walk past the shooter or shooters and get fired upon from the rear. They saw casualties in the hallway and a scene of mass carnage in the classrooms, with many still alive. Although the shooter was eventually identified, he was not immediately apparent, and they were not certain whether other shooters lurked. This seemed a distinct possibility. As one police sergeant later reflected: "How could one person do all this damage alone with handguns?"

Some people have questioned why the police could not force entry into the building more quickly. First, most police units do not carry bolt cutters or other entry devices; such tools would rarely be used by squad car officers. They usually are carried only in the vans of special police units. Second, the windows on the first floor are very narrow, as on all floors of Norris Hall. A thin student could climb through them; a heavily armed officer wearing bulletproof vest could not. Knocking down a door with a vehicle was not possible given the design and site of the building. The auditorium connecting Norris Hall with Holden Hall and shared by both could have been used as an entry path, but it would have taken longer to get in by first running into Holden Hall, going through it, and then up the stairs to Norris Hall. The police ERT had the capability of receiving plans of the buildings by radio from the fire department, but that would have taken too long and was not needed in the event.

During the shooting, a student took pictures from his cell phone that were soon broadcast on television. They showed many police outside of Norris Hall behind trees and cars, some with guns drawn, not moving toward the gunfire. Most of them were part of a perimeter established around the building after the first officers on the scene made entry. The police were following standard procedure to surround the building in case the shooter or shooters emerged firing or trying to escape. What was not apparent was that the first officers on the scene already were inside.

Once the shooting stopped, the first police on the scene switched modes and became a rescue team. Four officers carried out a victim using a diamond formation, two actually doing the carrying and two escorting with guns drawn. At this point, it still was not known whether there was a second shooter. The police carried several victims who were still alive to the lawn outside the building, where they were turned over to a police-driven SUV that took the first victims to emergency medical treatment. (The emergency medical response is discussed in Chapter IX.)

A formal incident commander and emergency operations center was not set up until after the shooting was over mainly because events unfolded very rapidly. A more formal process was used for the follow-up investigation.

UNIVERSITY MESSAGES

When university officials were apprised of the Norris Hall shootings, they were horrified. Vice Provost Ford explained the events as follows (continuing his statement presented to the panel from the previous chapter):

At approximately 9:45 a.m., the Policy Group received word from the Virginia Tech police of a shooting in Norris Hall. Within five minutes, a notification was issued by the Policy Group and transmitted to the university community which read:

"A gunman is loose on campus. Stay in buildings until further notice. Stay away from all windows."

Also activated was the campus emergency alert system. The voice message capability of that system was used to convey an emergency message throughout the campus. Given the factual information available to the Policy Group, the reasonable action was to ask people to stay in place. The Policy Group did not have evidence to ensure that a gunman was or was not on the loose, so every precaution had to be taken. The Virginia Tech campus contains 153 major buildings,[52] 19 miles of public roads, is located on 2,600 acres of land, and as many as 35,000 individuals might be found on its grounds at any one time on a typical day. Virginia Tech is very much like a small city. One does not entirely close down a small city or a university campus.

Additionally, the Policy Group considered that the university schedule has a class change between 9:55 a.m. and 10:10 a.m. on a MWF schedule. To ensure some sense of safety in an open campus environment, the Policy Group decided that keeping people inside existing buildings if they were on campus and away from campus if they had not yet arrived was the right decision. Again, we made the best decision we could based on the information available. So at approximately 10:15 a.m. another message was transmitted which read:

"*Virginia Tech has cancelled all classes. Those on campus are asked to remain where they are, lock their doors, and stay away from windows. Persons off campus are asked not to come to campus."*

At approximately 10:50 a.m., Virginia Tech Police Chief Flinchum and Blacksburg Police Chief Crannis arrived to inform the Policy Group about what they had witnessed in the aftermath of the shootings in Norris Hall.

Chief Flinchum reported that the scene was bad; very bad. Virginia state police was handling the crime scene. Police had one shooter in custody and there was no evidence at the time to confirm or negate a second shooter, nor was there evidence at the time to link the shootings in West Ambler Johnston to those in Norris Hall. The police informed the Policy Group that these initial observations were ongoing investigations.

Based upon this information and acting upon the advice of the police, the Policy Group immediately issued a fourth transmittal which read:

"In addition to an earlier shooting today in West Ambler Johnston, there has been a multiple shooting with multiple victims in Norris Hall. Police and EMS are on the scene. Police have one shooter in custody and as part of routine police procedure, they continue to search for a second shooter.

"All people in university buildings are required to stay inside until further notice. All entrances to campus are closed."

Information about the Norris Hall shootings continued to come to the Policy Group from the scene. At approximately 11:30 [a.m.], the Policy Group issued a planned faculty–staff evacuation via the Virginia Tech web site which read:

"Faculty and staff located on the Burruss Hall side of the drill field are asked to leave their office and go home immediately. Faculty and staff located on the War Memorial/ Eggleston Hall side of the drill field are asked to leave their offices and go home at 12:30 p.m."

At approximately 12:15 p.m., the Policy Group released yet another communication via the Virginia Tech web site which further informed people as follows:

"Virginia Tech has closed today Monday, April 16, 2007. On Tuesday, April 17, classes will be cancelled. The university will remain open for administrative operations. There will be an additional university statement presented today at noon.

[52] From another university source, we identified 131 major buildings and several more under construction. In any event, it is a large number of structures.

"All students, faculty and staff are required to stay where they are until police execute a planned evacuation. A phased closing will be in effect today; further information will be forthcoming as soon as police secure the campus.

"Tomorrow there will be a university convocation/ceremony at noon at Cassell Coliseum. The Inn at Virginia Tech has been designated as the site for parents to gather and obtain information."

A press conference was held shortly after noon on April 16, 2007, and President Charles W. Steger issued a statement citing "A tragedy of monumental proportions." Copies of that statement are available on request.

The Policy Group continued to meet and strategically plan for the events to follow. A campus update on the shootings was issued at another press conference at approximately 5:00 p.m.

It should be noted that the above messages were sent after the full gravity of what happened at Norris Hall had been made known to the Policy Group. They were too late to be of much value for security. The messages still were less than full disclosure of the situation. There may well have been a second shooter, and the university community should have been told to be on the lookout for one, not that the continued search was just "routine police procedure." When almost 50 people are shot, what follows is hardly "routine police procedure." The university appears to have tempered its messages to avoid panic and reduce the shock and fright to the campus family. But a more straightforward description was needed. The messages still did not get across the enormity of the event and the loss of life. By that time, rumors were rife. The events were highly disturbing and there was no way to sugarcoat them. Straight facts were needed.

OTHER ACTIONS ON THE SECOND AND THIRD FLOORS

While the shootings were taking place in classrooms on the second floor of Norris Hall, people on the other floors and in offices on the second floor tried to flee or take refuge—with one exception. Professor Kevin Granata from the third floor guided his students to safety in a small room, locked the room and went to investigate the gunfire on the second floor. He was shot and killed. People who did take refuge in locked rooms were badly frightened by gunfire and the general commotion, but all of them survived.

In the first minutes after they arrived, the police could not be sure that all of the shooters were dead. The police had to be careful in clearing all rooms to ensure that there was not a second shooter mixed in with the others. In fact, perpetrators can often blend with their victims, Groups of police went through the building clearing each office, lab, classroom, and closet. When they encountered a group of people hiding in a bathroom or locked office, they had to be wary. The result was that many people were badly frightened a second time by the police clearing actions. Some were sent downstairs accompanied by officers and others were left to make their own way out. Although quite a few officers were in the building at this time, they still did not have sufficient members to clear all areas and simultaneously escort out every survivor. It also appears that there was inadequate communication between the police who were clearing the building and those outside guarding the exits.

For example, one group of professors and staff was hiding behind the locked doors of the Engineering Department offices on the third floor. When they were cleared by police to evacuate, they were directed down a staircase toward an exit where they found a chained door with police outside pointing guns at them. One of them remembered that there was an exit through the auditorium to Holden Hall and they left that way.

The group of students from Professor Granata's third-floor class that hid in a small locked office were frightened by officers approaching with guns at the ready, but then were escorted safely out of the building.

The police had their priorities straight. Although many survivors were frightened, the police understandably were focused on clearing the building safely and quickly. Had there been a second shooter not found quickly, the police would have wasted manpower escorting people out instead of searching for and neutralizing the shooter.

ACTION ON THE FIRST FLOOR

According to VTPD Chief Flinchum:

> When officers entered Norris Hall, two stayed on the first floor to secure it. One officer said one or two people came out of rooms and were evacuated. Officers on the second floor took survivors down to the first floor on the Drillfield side of Norris, but they had to shoot the lock on the chained door to get out. When they did this, other officers entered Norris and began initial clearing of the first floor while the other teams were clearing the third and second floors. The first floor was cleared again by SWAT after the actions on the second floor were completed.

This all was appropriate, thorough police procedure.

THE TOLL

In about 10 minutes, one shooter armed with handguns shot 47 students and faculty, of whom 30 died. The shooter's self-inflicted wound made the toll 48.

Of the seven faculty conducting classes, five were fatally shot. Three were standing in the front of their classrooms when the gunman walked in. One was shot barricading the door, and one shot while investigating the sounds after getting his class to safety on the third floor. They were brave and vulnerable.

Based on university records, 148 students were on the rolls of classes held at 9:05 a.m. in Norris Hall on April 16. At least 31 and possibly a few more missed classes or had classes cancelled that day. So at least 100 students were in the building, possibly as many as 120, including a few not enrolled in the classes. (The statistics are inexact because not all Norris Hall students responded to a university survey of their whereabouts that day.) Of the students present, 25 were killed, 17 were shot and survived, 6 were injured jumping from windows, and 4 were injured from other causes.[53]

Room 211 suffered the most student casualties (17). The other rooms with casualties were 207 (11), 206 (11), 204 (10), 205 (1), and 306 (1).

In addition to the classes, there were many other people in the building at the time of the shootings, including staff of the dean's office, other faculty members with offices in the building, other students, and janitorial staff. None of them was injured.

When the shooting stopped, about 75 students and faculty were uninjured, some still in classroom settings and others in offices or hiding in restrooms. With over 200 rounds left, the toll could have been higher if the police had not arrived when they did, as noted earlier.

Table 2 and Table 3 at the end of this chapter show the numbers of students and faculty who were killed and injured, by room, based on the university's research.

KEY FINDINGS

Overall, the police from Virginia Tech and Blacksburg did an outstanding job in responding quickly and using appropriate active-shooter procedures to advance to the shooter's location and to clear Norris Hall.

[53] There are small inconsistencies in the tallies of injuries among police, hospitals, and university because some students sought private treatment for minor injuries, and the definition of "injury" used.

The close relationship of the Virginia Tech Police Department and Blacksburg Police Department and their frequent joint training saved critical minutes. They had trained together for an active shooter incident in university buildings. There is little question their actions saved lives. Other campus police and security departments should make sure they have a mutual aid arrangement as good as that of the Virginia Tech Police Department.

Police cannot wait for SWAT teams to arrive and assemble, but must attack an active shooter at once using the first officers arriving on the scene, which was done. The officers entering the building proceeded to the second floor just as the shooting stopped. The sound of the shotgun blast and their arrival on the second floor probably caused Cho to realize that attack by the police was imminent and to take his own life.

Police did a highly commendable job in starting to assist the wounded, and worked closely with the first EMTs on the scene to save lives.

Several faculty members died heroically while trying to protect their students. Many brave students died or were wounded trying to keep the shooter from entering their classrooms. Some barricading doors kept their bodies low or to the side and out of the direct line of fire, which reduced casualties.

Several quick-acting students jumped from the second floor windows to safety, and at least one by dropping himself from the ledge, which reduced the distance to fall. Other students survived by feigning death as the killer searched for victims.

People were evacuated safely from Norris Hall, but the evacuation was not well organized and was frightening to some survivors. However, being frightened is preferable to being injured by a second shooter. The police had their priorities correct, but they might have handled the evacuation with more care.

RECOMMENDATIONS

VIII-1 Campus police everywhere should train with local police departments on response to active shooters and other emergencies.

VIII-2 Dispatchers should be cautious when giving advice or instructions by phone to people in a shooting or facing other threats without knowing the situation. This is a broad recommendation that stems from reviewing other U.S. shooting incidents as well, such as the Columbine High School shootings. For instance, telling someone to stay still when they should flee or flee when they should stay still can result in unnecessary deaths. When in doubt, dispatchers should just be reassuring. They should be careful when asking people to talk into the phone when they may be overheard by a gunman. Also, local law enforcement dispatchers should become familiar with the major campus buildings of colleges and universities in their area.

VIII-3 Police should escort survivors out of buildings, where circumstances and manpower permit.

VIII-4 Schools should check the hardware on exterior doors to ensure that they are not subject to being chained shut.

VIII-5 Take bomb threats seriously. Students and staff should report them immediately, even if most do turn out to be false alarms.

Table 2. Norris Hall Student Census for April 16, 2007 9:05 a.m. Classes

Room No.	Total Students on Class Roll	Total Students Accounted For:						Students Injured** by Gunshot	Used Windows To Escape	
		Killed or Later Died	Injured	Not Physically Injured	Did Not Attend Class	Status Not Verified	Total		Injured*	Not Injured*
200	14*	0	0	0	14**	0	14	0		
204	23	1	9	6	5	2	23	3	6	4
205	14	0	1	8	3	2	14	0		
206	14	9	2	2	1	0	14	2		
207	15	4	7	1	3	0	15	6		
211	22	11	6	0	4	1	22	6		
306	37	0	1	20	1	15	37	0		
Labs	9	0	0	9	0	0	9	0		
Totals	**148**	**25**	**26**	**47**	**31**	**20**	**148**	**17**	**6**	**4**

* Included in "Total Students Accounted For"

** Class was cancelled that day

Table 3. Norris Hall Faculty Census

Room #	Total Faculty Scheduled	Total Faculty Accounted For					
		Killed or Later Died	Injured	Not Physically Injured	Did Not Attend Class	Status Not Verified	Total
200	1	0	0	0	1**		1
204	1	1	0	0			1
205	1	0	0	1			1
206	1	1	0	0			1
207	1	1	0	0			1
211	1	1	0	0			1
306	1	0	0	1			1
225/hallway	1	1	0	0			1
Totals	**8**	**5**	**0**	**2**	**1**		**8**

***** Class was cancelled that day

These tables were provided by the Virginia Tech administration

ADDITIONS AND CORRECTIONS

Cho Surveillance of Norris Hall: Addition – In Spring 2007**,** Cho had a class at Norris Hall. Between February and April 2007 he was seen numerous times in and around Norris Hall at times other than when he had class, possibly casing the building. He picked a Monday for his attack, a day when his class was not in session, which lessened the chance of confronting students and faculty whom he knew and who knew him.

Handling of Bomb Threat Note: p. 89, Correction – Cho left a note saying there was a bomb in Norris Hall not on the inside of one of the chained doors as was stated in the Report, but rather on the inside of an interior door leading to the vestibule where the exit door was chained. Also, that note was found by a faculty member and given to a custodian on the second floor to take to the Dean's Office, not carried there by the faculty member herself. Virginia Tech bomb threat policy required that anyone discovering or receiving a bomb threat should immediately report the threat to the VTPD.

Doors Shot At: p. 94, Correction – Cho had chained all three public entrances to Norris Hall, using a lock and chain on each. Police tried to get into one of the chained entrances and then a second. They shot at the lock on the second door but could not break it. The metal chain was on the inside and there was little play in the door. Police successfully shot open the conventional lock on an exterior door leading to a maintenance shop, from which they gained entrance to the rest of Norris Hall. They did not shoot at all three chained doors as reported in the text.

Student Victim Status: p. 100, Addition – The one student in Room 211 of Norris Hall who was listed in Table 2 as "status not verified" was later identified as Clay Violand, the only student unharmed in that classroom. The total number of people present but unharmed during the shootings in Norris Hall increases by one, to 47.

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Chapter IX.
EMERGENCY MEDICAL SERVICES RESPONSE

The tragic scenes that occurred at Virginia Tech are the worst that most emergency medical service (EMS) providers will ever see. Images of so many students and faculty murdered or seriously injured in such a violent manner and the subsequent rescue efforts can only be described by those who were there. This chapter discusses the emergency medical response on April 16 to victims including their pre-hospital treatment, transport, and care in hospitals.

Interviews were conducted with first responders, emergency managers, and hospital personnel (physicians, nurses, and administrators) to determine:

- The on-scene EMS response.
- Implementation of hospital multi-casualty plans and incident command systems.
- Pre-hospital and in-hospital initial patient stabilization.
- Compliance with the National Incident Management System (NIMS).
- Communications systems used.
- Coordination of the emergency medical care with police and EMS providers.

Evaluating patient care subsequent to the initial pre-hospital and hospital interventions was beyond the scope of this investigation. Fire department personnel were not interviewed because there were no reports of their involvement in patient care activities.

Although there is always opportunity for improvement, the overall EMS response was excellent and the lives of many were saved. The challenges of systematic response, scene and provider safety, and on-scene and hospital patient care were effectively met. Responders are to be commended. The results in terms of patient care are a testimony to their medical education and training for mass casualty events, dedication, and ability to perform at a high level in the face of the disaster that struck so many people.

The Virginia Tech Rescue Squad and Blacksburg Volunteer Rescue Squad were the primary agencies responsible for incident command, triage, treatment, and transportation. Many other regional agencies responded and functioned under the Incident Command System (ICS). The Blacksburg Volunteer Rescue Squad (BVRS) personnel and equipment response was timely and strong. Virginia Tech Rescue Squad (VTRS), the lead EMS agency in this incident, is located on the Virginia Tech campus and is the oldest collegiate rescue squad of its kind nationwide. It is a volunteer, student-run organization with 38 members.[54] Their actions on April 16 were heroic and demonstrated courage and fortitude.

WEST AMBLER JOHNSTON INITIAL RESPONSE

The first EMS response was to the West Ambler Johnston (WAJ) residence hall incident. At 7:21 a.m., VTRS was dispatched to 4040 WAJ for the report of a patient who had fallen from a loft. In 3 minutes, at 7:24 a.m., VT Rescue 3 was en route. While en route, dispatch advised that a resident assistant reported a victim lying against a dormitory room door and that bloody footprints and a pool of blood were seen on the floor. VT Rescue 3 arrived on scene at 7:26 a.m., 5 minutes from the time of dispatch. This response time falls within the nationally accepted range.[55]

[54] VTRS. (2007). *April 16, 2007: EMS Response.* Presentation to the Virginia Tech Review Panel. May 21, 2007, The Inn at Virginia Tech.

[55] NFPA (2004). NFPA 1710: *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments.* National Fire Protection Association: Battery March Park, MA.

At 7:29 a.m., Rescue 3 accessed the dorm room to find two victims with gunshot wounds, both obviously in critical condition. At 7:31 a.m., it requested a second advanced life support (ALS) unit and ordered activation of the all-call tone requesting all available Virginia Tech rescue personnel to respond to the scene. The "all-call" request is a normal procedure for VTRS to respond to an incident with multiple patients. Personnel from BVRS responded to WAJ as well.

At 7:48 a.m., VT Rescue 3 requested that Carilion Life-Guard helicopter be dispatched and was informed that its estimated time of arrival was 40 minutes. It was decided to dispatch the helicopter to Montgomery Regional Hospital (MRH). Carilion Life-Guard then advised that they were grounded due to weather and never began the mission.

One of the victims in 4040 WAJ was a 22-year-old male with a gunshot wound to the head. He was in cardiopulmonary arrest. CPR was initiated, and he was immobilized using an extrication collar and a long spine board. VT Rescue 3 transported him to MRH. During communications with the MRH online physician, CPR was ordered to be discontinued. He arrived at the hospital DOA.[56]

The second victim was an 18-year-old female with a gunshot wound to the head. She was treated with high-flow oxygen via mask, two IVs were established, and cardiac monitoring was initiated. She was immobilized with an extrication collar and placed on a long spine board. At 7:44 a.m., she was transported by VT Rescue 2 to MRH. During transport, her level of consciousness began to deteriorate and her radial pulse was no longer palpable.[57] Upon arrival at MRH, endotracheal intubation was performed. At 8:30 a.m., she was transferred by ground ALS unit to Carilion Roanoke Memorial Hospital (CRMH), a Level I trauma center in Roanoke, Virginia.[58]

[56] EMS Patient Care Report Q0669603.

[57] EMS Patient Care Report Q0669604.

[58] Turner, K. N., and Davis, J. (2007). *Public Safety Timeline for April 16, 2007*. Unpublished Report. Montgomery County Department of Emergency Services, p. 4.

Following CPR that occurred en route she was pronounced dead at CRMH.[59]

Based on the facts known, the triage, treatment, and transportation of both WAJ victims appeared appropriate. The availability of helicopter transport likely would not have affected patient outcomes. Their injuries were incompatible with survival.

NORRIS HALL INITIAL RESPONSE

At 9:02 a.m., VT Rescue 3 returned to service following the WAJ incident. VT Rescue 2 continued equipment cleanup at MRH when the call for the Norris Hall shootings came in. At approximately 9:42 a.m., VTRS personnel at their station overheard a call on the police radio advising of an active shooter at Norris Hall. Many EMS providers were about to respond to the worst mass shooting event on a United States college campus.

Upon hearing the police dispatch of a shooting at Norris Hall, the VTRS officer serving as EMS commander immediately activated the VTRS Incident Action Plan and established an incident command post at the VTRS building. VT Rescue 3, staffed with an ALS crew, stood by at their station. At about 9:42 a.m., VTRS requested the Montgomery County emergency services coordinator to place all county EMS units on standby and for him to respond to the VTRS Command Post. "Standby" means that all agency units should be staffed and ready to respond. Each agency officer in charge is supposed to notify the appropriate dispatcher when the units are staffed.

The Montgomery County Communications Center immediately paged out an "all call" alert (9:42 a.m.) advising all units to respond to the scene at Norris Hall.

The EMS responses to West Ambler Johnston and Norris halls occurred in a timely manner. However, for the shootings at Norris Hall, all EMS units were dispatched to respond to the

[59] EMS Patient Care Report Q0019057.

scene at once contrary to the request. Subsequently, the Montgomery County emergency services coordinator requested dispatch to correct the message in time to allow for most of the incoming squads to proceed to the secondary staging area at the BVRS station.

At 9:46 a.m., VTRS was dispatched by police to Norris Hall for multiple shootings—4 minutes after VTRS monitored the incident (9:42 a.m.) on the police radio. The VTRS EMS commander advised VT dispatch that the VTRS units would stand by at the primary staging site until police secured the shooting area. At 9:48 a.m., the EMS commander also requested the VT police dispatcher to notify all responding EMS units from outside Virginia Tech to proceed to the secondary staging area at BVRS instead of responding directly to Norris Hall.

The VTPD and the Montgomery County Communications Center issued separate dispatches for EMS units, which led to some confusion in the EMS response.

EMS INCIDENT COMMAND SYSTEM

At the national level, Homeland Security Presidential Directives (HSPDs) 5 and 8 require all federal, state, regional, local, and tribal governments, including EMS agencies, to adopt the NIMS, including a uniform ICS.[60] The Incident Management System is defined by Western Virginia EMS Council in their Mass Casualty Incident (MCI) Plan as:

> A written plan, adopted and utilized by all participating emergency response agencies, that helps control, direct and coordinate emergency personnel, equipment and other resources from the scene of an MCI or evacuation, to the transportation of patients to definitive care, to the conclusion of the incident.[61]

Overall, the structure of the EMS ICS was effective. The ICS as implemented during the incident is compared in Figure 13 and Figure 14 to NIMS ICS guidelines. Figure 13 shows the Virginia Tech EMS ICS structure as implemented in the incident.[62] Although it did not strictly follow NIMS guidelines, it included most of the necessary organization. Figure 14 shows the Model ICS structure based on the NIMS guidelines.

EMS Command – An EMS command post was established at VTRS. The BVRS officer-in-charge who arrived at Norris Hall reportedly was unable to determine if an EMS ICS was in place. Since each agency has its own radio frequency, the potential for miscommunication of critical information regarding incident command is possible. To enhance communications, EMS command reportedly switched from the VTRS to the BVRS radio frequency. In addition, to shift routine communications from the main VT frequency, EMS command requested units to switch to alternate frequency, VTAC 1. Some units were confused by the term VTAC 1. Eventually, all units switched to the Montgomery County Mutual Aid frequency.

The fact that BVRS was initially unaware that VTRS had already established an EMS command post could have caused a duplication of efforts and further organizational challenges. Participants interviewed stated that once a BVRS officer reported to the EMS command post, communications between EMS providers on the scene improved. The Montgomery County emergency management coordinator was on the scene and served as a liaison between the police tactical command post and the EMS incident command post, which also helped with communications.

Because BVRS and VTRS are on separate primary radio frequencies, BVRS reportedly did not know where to stage their units. In addition, BVRS units reportedly did not know when the police cleared the building for entry.

[60] Bush, G. W. (2003). December 17, 2003 Homeland Security Presidential Directive/HSPD–8.

[61] WVEMS. (2006). *Mass Casualty Incident Plan: EMS Mutual Aid Response Guide*: Western Virginia EMS Council, Section 2.1.7, p. 2.

[62] VTRS. (2007). *April 16, 2007: EMS Response.* Presentation to the Virginia Tech Review Panel. May 21, 2007, The Inn at Virginia Tech.

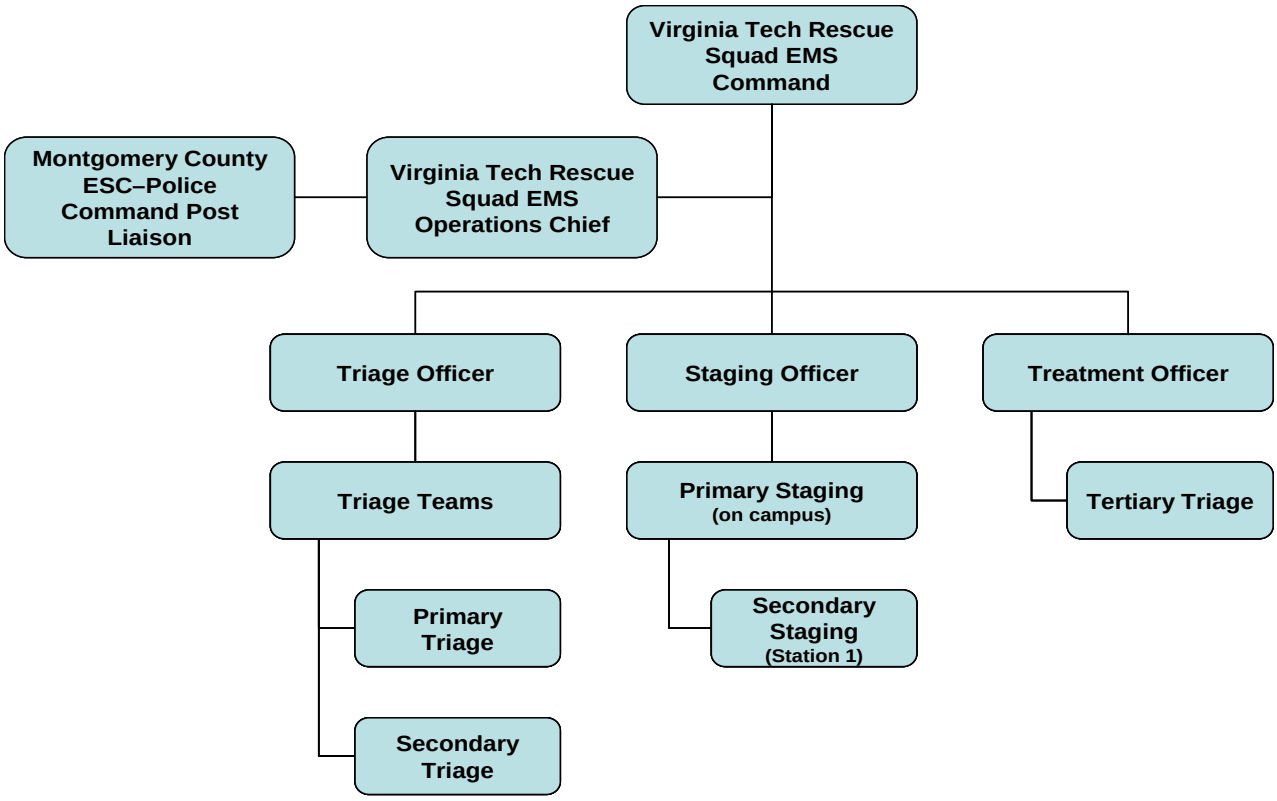


Figure 13. Virginia Tech EMS ICS as Implemented in the Incident

Another issue concerned the staging of units and personnel. EMS command correctly advised dispatch that assignments and staging would be handled by EMS command.[63]

Triage – The VTPD arrived at Norris Hall at 9:45 a.m. At 9:50 a.m., the VTPD and Blacksburg police emergency response teams (ERTs) arrived at Norris Hall, each with a tactical medic. At 9:50 a.m., two ERT medics entered Norris Hall where they were held for about 2 minutes inside the stairwell before being allowed to proceed. At 9:52 a.m., the two medics, one from VTRS and one from BVRS, began triage. Medics initially triaged those victims brought to the stairwells while police were moving them out of the building. As victims exited the building, some walked and some were carried out and transported by police SUV's and other mobile units to the safer EMS treatment areas.

The triage by ERT medics inside the Norris Hall classrooms had two specific goals: first, to identify the total number of victims who were alive or dead; and second, to move ambulatory victims to a safe area where further triage and treatment could begin. The tactical medics employed the START triage system (Simple Triage and Rapid Treatment) to quickly assess a victim and determine the overall incident status. The START triage is a "method whereby patients in an MCI are assessed and evaluated on the basis

[63] Turner, K.N., & Davis, J. (2007). *Public Safety Timeline for April 16, 2007*. Unpublished Report. Montgomery County Department of Emergency Services, p. 6.

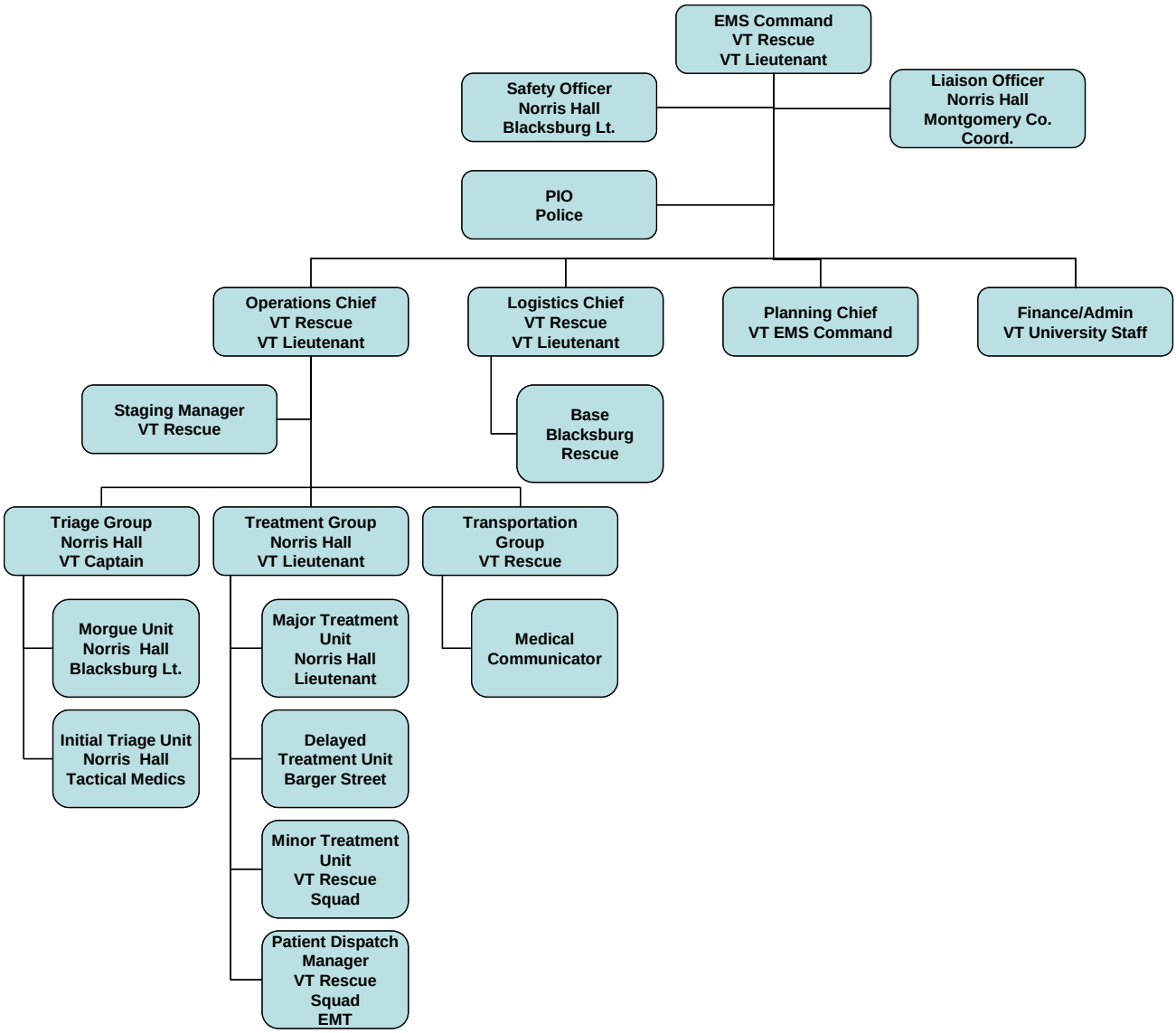


Figure 14. Model ICS Based on the NIMS Guidelines

of the severity of injuries and assigned to treatment priorities."[64] Patients are classified in one of four categories (Figure 15). Colored tags are affixed to patients corresponding to these categories.

In an incident of this nature, the triage team must concentrate on the overall situation instead

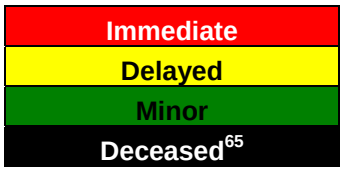


Figure 15. START Triage Patient Classifications

[64] WVEMS. (2006). *Mass Casualty Incident Plan: EMS Mutual Aid Response Guide*: Western Virginia EMS Council, Section 2.1.8, p. 2.

[65] Critical Illness and Trauma Foundation, Inc. (2001). *START—Simple Triage and Rapid Treatment*. http://www.citmit.org/start/default.htm

of focusing on individual patient care. Patient care is limited to quick interventions that will make the difference between life and death. The medics systematically approached the initial triage, with one assessing victims in the odd-numbered rooms on the second floor of Norris Hall while the other assessed victims in the even-numbered rooms. The medics were able to quickly identify those victims who were without vital signs and would likely not benefit from medical care. This initial triage by the two tactical medics accompanying the police was appropriate in identifying patient viability. The medics reported "a tough time with radio communications traffic" while triaging in Norris Hall.

The triage medics identified several patients who required immediate interventions to save their lives. Some victims with chest wounds were treated with an Asherman Chest Seal (Figure 16). It functions with a flutter valve to prevent air from entering the chest cavity during inhalation and permits air to leave the chest cavity during exhalation. This is a noninvasive technique that can be applied quickly with low risk. It was reported that a female victim with chest wounds benefited by the immediate application of the seal. Since the scene was not yet secured at this point to allow other EMS providers to enter, the tactical medics quickly instructed some police officers how to use the seal.

Figure 16. Asherman Chest Seal[66]

[66] ACS (2007). Asherman Chest Seal. http://www.compassadvisors.biz

A decision was quickly made to treat a 22-year-old male victim who exhibited a profuse femoral artery bleed by applying a commercial-brand tourniquet (Figure 17) to control the bleeding. The patient was transported to MRH, where surgical repair was performed and he survived. The application of a tourniquet was likely a lifesaving event.

Figure 17 Tourniquet[67]

At approximately 10:09 a.m., VTPD dispatch notified EMS command that the "shooter was down" and that EMS crews could enter Norris Hall. EMS command assigned a lieutenant from VTRS to become the triage unit leader. Triage continued inside and in front of Norris Hall. Some critical patients at the Drillfield side and others at the secondary triage (critical treatment unit) Old Turner Street side of Norris Hall were placed in ambulances and transported directly to hospitals. Noncritical patients were moved to a treatment area at Stanger and Barger Streets.

A BVRS officer and crew arrived at Norris Hall and began to retriage victims. Their reassessment confirmed that 31 persons were dead. Based on the evidence available, the decision not to attempt resuscitation on those originally triaged as dead was appropriate. No one appeared to have been mistriaged. A medical director (emergency physician) for a Virginia State Police Division SWAT team responded with his team to the scene. He was primarily staged at Burress Hall and was available to care for wounded

[67] Medgadget (2007). http://www.medgadget.com

officers if needed. There were no reports of injuries to police officers.

Interviews of prehospital and hospital personnel revealed that triage ribbons or tags were not consistently used on victims. The standard triage tags were used on some patients but not on all. These triage tags, shown in Figure 18, are part of the Western Virginia EMS Trauma Triage Protocol and can assist with record keeping and patient follow-up.[68] Not using the tags may have led to some confusion regarding patient identification and classification upon arrival at hospitals.

Treatment – Patients were moved to the treatment units based on START guidelines. The treatment group was divided into three units: a critical treatment unit, a delayed treatment unit and a minor treatment unit. The critical treatment unit was located at the Old Turner Street Side of Norris Hall where patients with immediate medical care needs (red tag) received care. Patients who were classified as less critical (yellow tag) were moved to the delayed treatment unit at Stanger and Barger Streets. Patients with minor injuries, including walking wounded/ worried well (green tag) were moved to a minor treatment unit at VTRS (Figure 19). "Worried well" are those who may not present with injuries but with psychological or safety issues.

Patients were moved to the treatment units in various ways. Some critical patients were carried out of Norris Hall by police and EMS personnel. Others were moved via vehicles, while those less critical walked to the delayed treatment or minor treatment units. EMS command assigned leaders to each of the units.

The weather was a significant factor with wind gusts of up to 60 mph grounding all aeromedical services and hampering the use of EMS equipment. This included tents, shelters, and treatment area identification flags that could not be

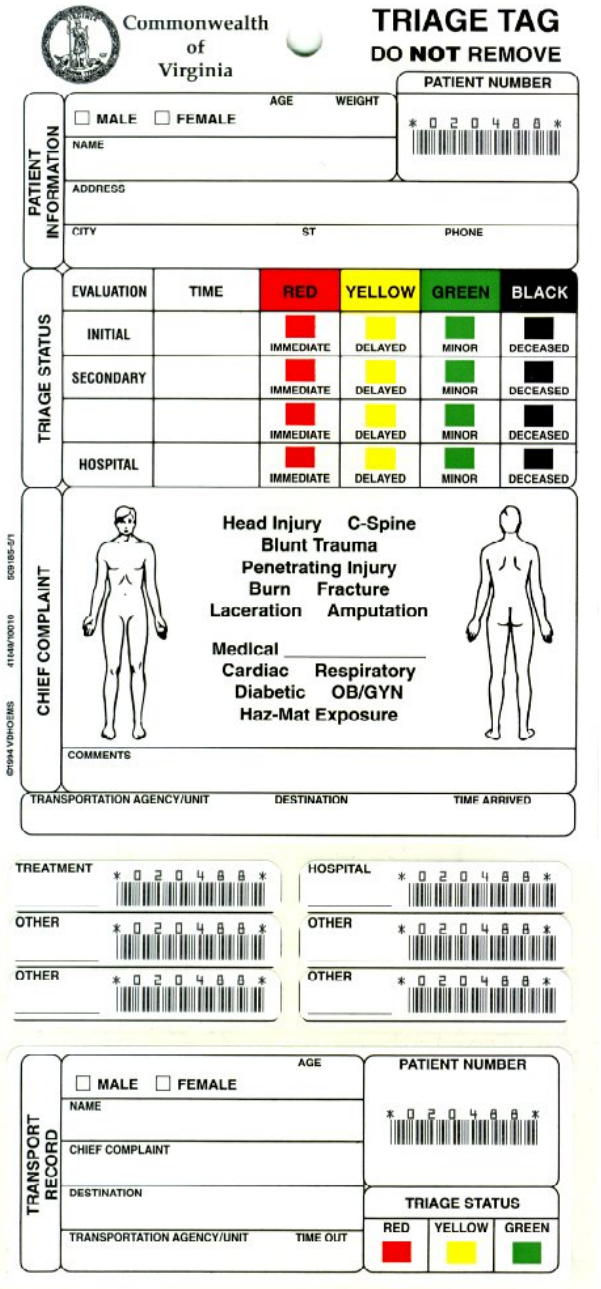


Figure 18. Virginia Triage Tag

set up or maintained. Large vehicles such as trailers and mobile homes, often used for temporary shelter, had difficulty responding as high winds made interstate driving increasingly hazardous. The incident site was close to ongoing construction. High winds blew debris, increasing danger to patients and providers and impeding patient care. To protect the walking wounded/ worried well from the environment, patients

[68] WVEMS. (2006). *Mass Casualty Incident Plan: EMS Mutual Aid Response Guide*: Western Virginia EMS Council., Section 22.3, p. 13.

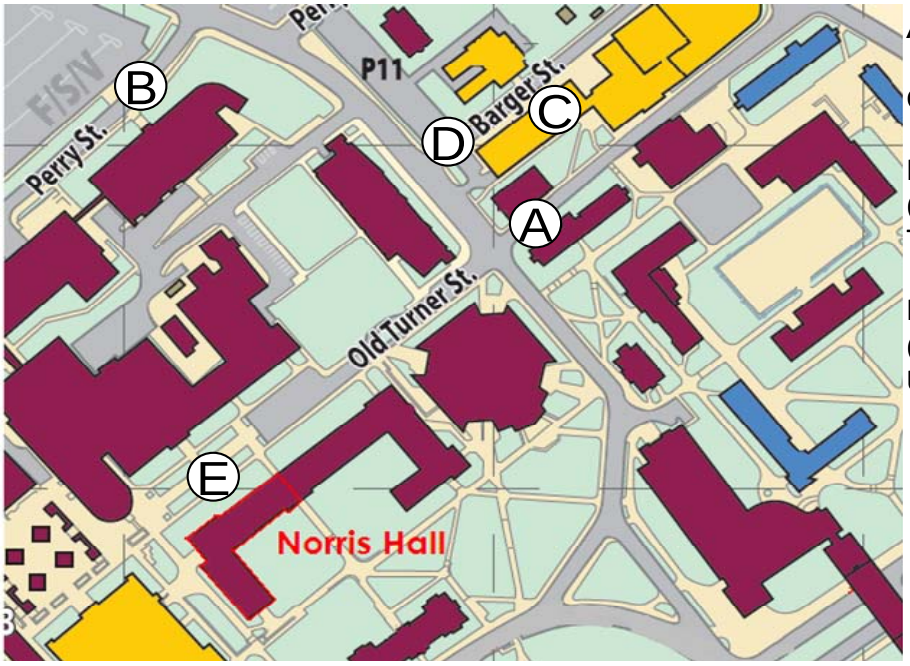


Figure 19. Initial Location of Treatment Units

were moved to the minor treatment unit at the VTRS building.

Twelve EMS patient care reports (PCRs) were available for review. In some cases PCRs were not completed, and in other cases not provided upon request. In multiple casualty incident situations, EMS providers can use standard triage tags in place of the traditional PCR; however, no triage tag records were provided, as noted earlier.

Based on the PCRs available and the interviews of EMS and hospital personnel, it appears that the patient care rendered to Norris Hall victims was appropriate.

Transportation – EMS command appointed a transportation group leader who assigned patients to ambulances and specific hospital destinations. Christiansburg Rescue Squad (CRS) responded with BLS and ALS units and was among the first in line at Norris Hall. CRS, BVRS, CPTS, and Longshop–McCoy Rescue Squad transported critical patients to area hospitals. CPTS ambulances from Giles, Radford, and Blacksburg as well as some of their Roanoke-based units, including Life-Guard flight and ground critical care crews, responded in mass to the incident either at Norris Hall or by interfacility transport of critical victims. By 10:51 a.m., all patients from Norris Hall were either transported to a hospital, or moved to the delayed or minor treatment units. In addition to VTRS, 14 agencies responded to the incident with 27 ALS ambulances and more than 120 EMS personnel (Table 4). Some agencies delayed routine interfacility patient transports or "back filled" covering neighboring communities through preset mutual aid agreements. Agency supervisors and administrators were working effectively behind the scenes procuring

Table 4. EMS Response
14 Assisting Agencies[69]

Montgomery County Emergency Services Coordinator
Blacksburg Volunteer Rescue Squad
Christiansburg Rescue Squad
Shawsville Rescue Squad
Longshop-McCoy Rescue Squad
Carilion Patient Transportation Services
Salem Rescue Squad
Giles Rescue Squad
Newport Rescue Squad
Lifeline Ambulance Service
Roanoke City Fire and Rescue
Vinton First Aid Crew
Radford University EMS
City of Radford EMS

the necessary resources and supporting the response of their EMS crews. These agencies demonstrated an exceptional working relationship, likely an outcome of interagency training and drills.

False Alarm Responses – At 10:58 a.m., EMS command was notified of a reported third shooting incident at the tennis court area on Washington Street that proved to be a false alarm. At 11:18 a.m., EMS command was notified of a bomb threat at Norris and Holden Halls that also proved to be false. Due to safety concerns, EMS command ordered the staging area moved from Barger St. to Perry St.

Post-Incident Transport of the Deceased – At 4:03 p.m., the medical examiner authorized removal of the deceased from Norris Hall to the medical examiner's office in Roanoke. Due to another rescue incident in the Blacksburg area, units were not available until 5:15 p.m. to begin transport of the deceased. Several options were considered including use of a refrigeration truck, funeral coaches, or EMS units. EMS command, in consultation with the medical examiner's representative, determined that EMS units from several companies would transport the deceased to Roanoke. In general, frontline EMS units are not used to transport the deceased. In this instance, however, the use of EMS units was acceptable because emergency coverage was not neglected and the rescuers felt that the sight of a refrigeration truck and funeral coaches on campus would be undesirable.

The decedents were placed two to a unit for transport. A serious concern raised by EMS providers was an order given by an unidentified police official that the decedents be transported to Roanoke under emergency conditions (lights and sirens). Due to safety considerations, EMS command modified this order.

The police order to transport the deceased under emergency conditions from Norris Hall to the medical examiners office in Roanoke was inappropriate for several reasons:

- It is not within law enforcement's scope of practice to order emergency transport (red lights and siren) of the deceased.
- There was no benefit to anyone by transporting under emergency conditions.
- A 30-minute or longer drive to Roanoke, during bad weather, with winds gusting above 60 mph, exposes EMS personnel to unnecessary risks.
- Transporting under emergency conditions increases the possibility of vehicle crashes with risk to civilians.

Critical Incident Stress Management – Although no physical injuries were reported, psychological and stress- related issues can subsequently manifest in EMS providers. Local and regional EMS providers participated in critical incident stress management activities such as defusings and debriefings immediately post-incident.

[69] VTRS. (2007). *April 16, 2007: EMS Response.* Presentation to the Virginia Tech Review Panel. May 21, 2007, The Inn at Virginia Tech.

HOSPITAL RESPONSE

Patients from Virginia Tech were treated at five area hospitals:

- Montgomery Regional Hospital
- Carilion New River Valley Hospital
- Lewis–Gale Medical Center
- Carilion Roanoke Memorial Hospital
- Carilion Roanoke Community Hospital

Twenty-seven patients are known to have been treated by local emergency departments. Some others who were in Norris Hall may have been treated at other hospitals, medical clinics, or doctor's offices including their own primary care providers; but there are no known accounts.

Overall, the local and regional hospitals quickly implemented their hospital ICS and mobilized resources. Aggressive measures were taken to postpone noncritical procedures, shift essential personnel to critical areas, reinforce physician staffing, and prepare for patient surge. Three hospitals initiated their hospital-wide emergency plans. One hospital, a designated Level I trauma center, did not feel that a full-scale, hospital-wide implementation of their emergency plan was necessary.

The most significant challenge early on was the lack of credible information about the number of patients each expected to receive. The emergency departments did not have a single official information source about patient flow. Likely explanations for this were (1) an emergency operations center (EOC) was not opened at the university, and (2) the Regional Hospital Coordinating Center did not receive complete information that it should have under the MCI plan.[70]

Preparedness, patient care/patient flow, and patient outcomes were reviewed for each of the receiving hospitals.

[70] Personal communications, Morris Reece, Near Southwest Preparedness Alliance, June 15, 2007.

Montgomery Regional Hospital – The MRH emergency department, a Level III trauma center, received 17 patients from the Virginia Tech incident; two from West Ambler Johnston and 15 from Norris Hall. The patients from WAJ arrived at 7:51 and 7:55 a.m. The first patient from WAJ was the 22-year-old male with a gunshot wound to the head who was DOA. No further attempts at resuscitation were made in the emergency department.

The second patient from WAJ was the 18-year-old female who arrived in critical condition with a gunshot wound to the head. Upon arrival to the emergency department, she was unable to speak and her level of consciousness was deteriorating. Airway control via endotracheal intubation was achieved using rapid sequence induction. At 8:30 a.m., she was transported by ALS ambulance to Carilion Roanoke Memorial Hospital, the Level I trauma center for the region. She died shortly after arrival at CRMH.

HOSPITAL PREPAREDNESS: At 9:45 a.m., MRH was notified of shots fired somewhere on the Virginia Tech campus. Because they were unsure of the number of shooters or whether the incident was confined to campus, MRH initiated a lockdown procedure. Since the killing of a hospital guard at MRH in August 2006 (the Morva incident mentioned in Chapter VII), there has been heightened awareness at MRH regarding security procedures. At 10:00 a.m., information became available confirming multiple gunshot victims. A "code green" (disaster code) was initiated and the following actions were taken:

- The hospital incident command center was opened and preassigned personnel reported to command.
- The hospital facility was placed on a controlled access plan (strict lockdown). Only personnel with appropriate identification (other than patients) could enter the hospital and then only through one entrance.
- All elective surgical procedures were postponed.

- Day surgery patients with early surgery times were sent home as soon as possible.
- The emergency department was placed on divert for all EMS units except those arriving from the Norris Hall incident. The emergency department was staffed at full capacity. A rapid emergency department discharge plan was instituted. Stable patients were transferred from the emergency department to the outpatient surgery suite.

At 10:05 a.m., the first patient from Norris Hall arrived via self-transport. This patient was injured escaping from Norris Hall. MRH was unable to determine the extent of the Norris Hall incident based on the history and minor injuries of this patient. The Regional Hospital Coordinating Center (RHCC) was notified of the incident and asked to open. Although the RHCC had early notification of the incident, they too were not able to ascertain the extent of the crisis initially.

At 10:14 and 10:15 a.m., two EMS-transported patients from Norris Hall arrived. It was evident that MRH might continue to receive expected and unexpected patients. In preparation for the surge, MRH took the following additional actions:

- The Red Cross was alerted and the blood supply reevaluated.
- Additional pharmaceutical supplies and a pharmacist were sent to the emergency department.
- A runner was assigned to assist with bringing additional materials to and from the emergency department and the pharmacy.
- Disaster supply carts were moved to the hallways between the emergency department and outpatient surgery.[71]

[71] Montgomery Regional Hospital. (2007). Montgomery Regional Hospital VT Incident Debriefing. April 23, 2007, p. 1.

At 10:30 a.m. as the above actions were being taken, four more gunshot victims arrived via EMS transport from Norris Hall. Between 10:45 and 10:55 a.m., five additional patients arrived via EMS. Command designated a public information officer and, by 11:00 a.m., a base had been established where staff and counselors could assist family and friends of patients.

By 11:15 a.m., MRH was still unclear about how many additional patients to expect. (They had a total of 12 by this time.) The operations chief instructed an emergency administrator to respond to the Virginia Tech incident as an on-scene liaison to determine how many more patients would be transported to MRH. At 11:20 a.m., the emergency department administrator reported to the Virginia Tech command center. MRH said that the face-to-face communications were helpful in determining how many additional patients to expect.

At 11:40 a.m., MRH received its last gunshot victim from the incident. By 11:51 a.m., its on-scene liaison confirmed that all patients had been transported. At 12:12 p.m., the EMS divert was lifted. At 13:04 and 13:10 p.m., however, two additional patients from the incident arrived by private vehicle. At 13:35 p.m., the code green was lifted.

Patient Care/Patient Flow/Patient Outcomes**:** In all, 15 patients arrived at MRH from the Norris Hall incident (Table 5) and were managed well.

An emergency department (ED) nurse/EMT-C was assigned to online medical direction and assisted with directing patients to other hospitals. EMS was instructed to transport four patients to Carilion New River Valley Hospital and five patients to Lewis–Gale Medical Center. One patient from the Norris Hall incident was transferred from MRH to CRMH in Roanoke.

The hospital representatives reported that there were problems with patient identification and tracking. As noted earlier:

Table 5. Norris Hall Victims Treated by Montgomery Regional Hospital

Injuries	Disposition
GSW left hand – fractured 4th finger	OR and admission
GSW to right chest – hemothorax	Chest tube in OR and admission
GSW to right flank	OR and admission to ICU
GSW left elbow, right thigh	Admitted
GSW x 2 to left leg	OR and admission
GSW right bicep	Treated and discharged
GSW right arm, grazed chest wall; abrasion to left hand	Admitted
GSW right lower extremity; laceration to femoral artery	OR and ICU
GSW right side abdomen and buttock	OR and ICU
GSW right bicep	Treated and discharged
GSW to face/head	Intubated and transferred to CRMH
Asthma attack precipitated by running from building	Treated and discharged
Tib/fib fracture due to jumping from a 2nd-story window	OR and admission
First-degree burns to chest wall	Treated and discharged
Back pain due to jumping from a 2nd-story window	Treated and discharged

- An EOC was not activated at Virginia Tech. Establishing an EOC can enhance communications and information flow to hospitals.
- Triage tags were not used for all patients. This would have provided a discrete number for identifying and tracking each patient.

MRH activated its ICS as shown in Figure 20.

ACCOMMODATIONS FOR PATIENTS' FAMILIES AND FRIENDS: MRH accommodated families and friends of patients they treated in their emergency department. MRH was challenged by the need to provide assistance to those who were unsure of the status or location of persons they were trying to find (possibly victims). An open space on the first floor was used for family and friends to gather. Since Virginia Tech had not yet opened an EOC or family assistance center, some victims' family and friends chose to proceed to the closest hospital. Several family members and friends of victims came to MRH even though their loved ones were never transported there.

A psychological crisis counseling team was assembled at MRH to provide services to victims, their families and loved ones, and hospital staff.[72] Virginia State Police troopers were assigned to the hospital and were helpful in maintaining security.

At 11:30 a.m., a surgeon arrived from Lewis–Gale Hospital and was emergently credentialed by the medical staff office. This is notable as Lewis–Gale and MRH are not affiliated.

Police departments often rely on hospitals to help preserve evidence and maintain a chain of custody. MRH was able to gather evidence in the emergency department and operating rooms, including bullets, clothing, and patient identification. At 1:45 p.m., the Virginia State Police notified the hospital that all bullets and fragments were to be considered evidence. Internal communications issues included:

- The Nextel system was overwhelmed. Clinical directors were too busy to retrieve and respond to messages.
- Monitoring EMS radio communications was difficult due to noise and chatter.
- There was deficient communications between the university and MRH.
- An EOC could have been helpful with communications

[72] Heil, J. et al. (2007). *Psychological Intervention with the Virginia Tech Mass Casualty: Lessons Learned in the Hospital Setting.* Report to the Virginia Tech Review Panel.

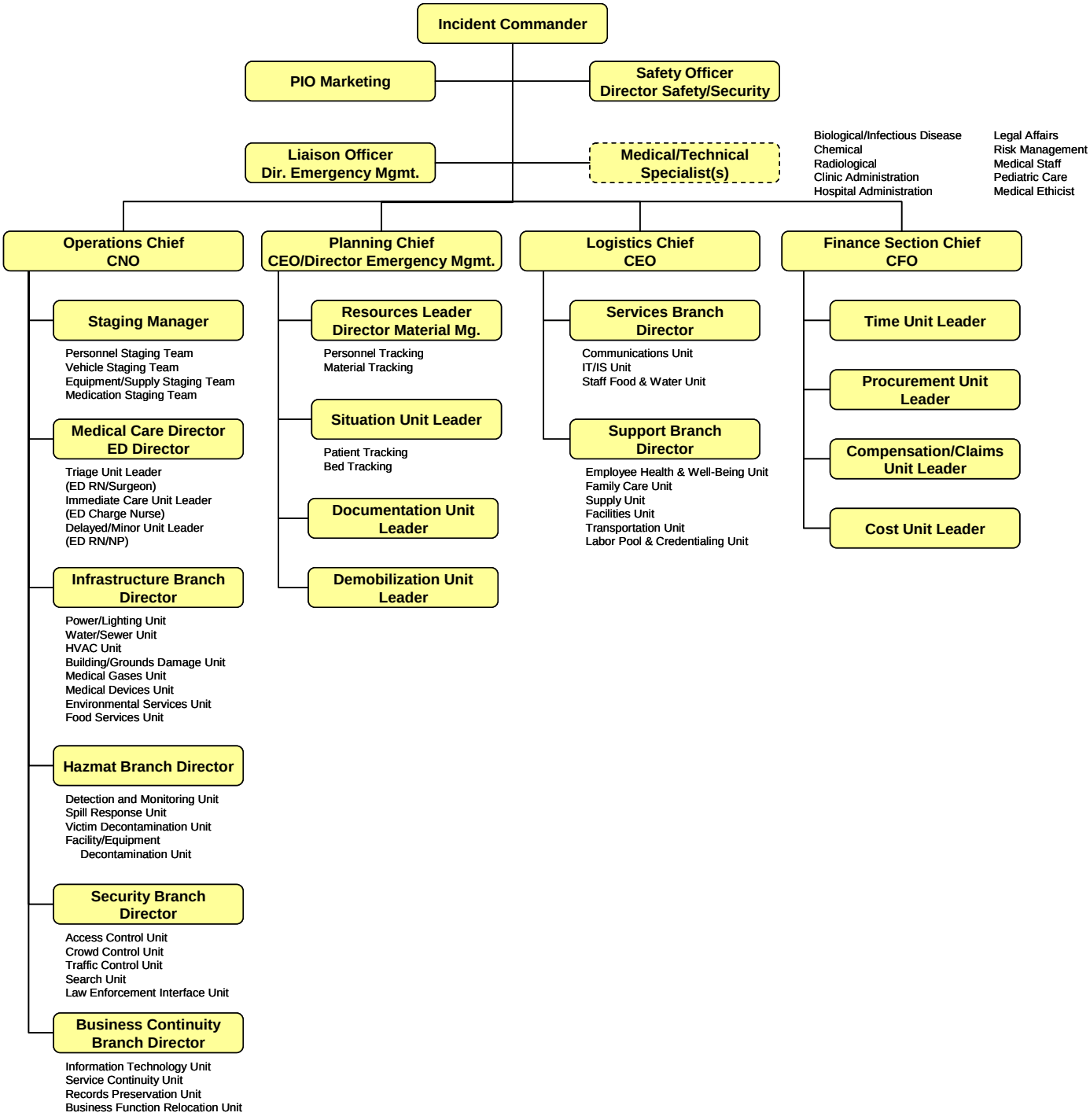


Figure 20. Montgomery Regional Hospital ICS

Carilion New River Valley Hospital – CNRVH is a Level III trauma center that received four patients with moderate to severe injuries.

Hospital Preparedness: CNRVH initially heard unofficial reports of the WAJ shootings. They heard nothing further for over 2 hours until they received a call from MRH and also from an RN/medic who was on scene. They were called again later by MRH and advised that they would be receiving patients with "extremity injuries." They were also notified that MRH was on EMS divert.

While waiting for patients to arrive, the emergency department (ED) physician medical director assumed responsibility for the "regular" ED patients while the on-duty physicians were preparing to treat patients from Norris Hall. The on-duty hospitalist (a physician who is hired by the hospital to manage in-patient care needs) reported to the ED to make rapid decisions on whether current patients would be admitted or discharged.

The hospital declared a "code green" and their EOC was opened at 11:50 a.m. The incident commander was a social worker who had special training in hospital ICS. Security surveyed all patients with a metal detection wand because they were unsure who may be victims or perpetrators. A SWAT team from Pulaski County responded to assist with security.

PATIENT CARE/PATIENT FLOW/PATIENT OUTCOMES: Four patients were transported by EMS to CNRVH, each having significant injuries. The hospital managed the patients well and could have handled more. Table 6 lists the patient injuries and dispositions.

Accommodations for Patients' Families and Friends: The hospital received many phone calls concerning the whereabouts of Virginia Tech shooting victims. Communications issues, particularly the lack of accurate information, were a big concern for the hospital; while providing accommodations for patients' families and friends and assisting others who were looking for their loved ones.

Table 6. Norris Hall Victims Treated by Carilion New River Valley Hospital

Injuries	Disposition
GSW to face, pre-auricular area, bleeding from external auditory canal, GCS of 7, poor airway, anesthesiologist recommended surgical airway	Surgical cricothyrotomy Transferred to CRMH by critical care ALS ambulance
GSW to flank and right arm, hypotensive	Immediately taken to OR; small bowel injury/resection
GSW to posterior thorax (exit right medial upper arm), additional GSWs to right buttock, and left lateral thigh	To OR for surgical repair of left femur fracture
GSW to right lateral thigh, exit thru right medial thigh, lodged in left medial thigh	Admitted in stable condition and observed; no vascular injuries

Lewis–Gale Medical Center – LGMC, a community hospital, received five patients from the Norris Hall shootings. The ICS structure used and their emergency response to the incident were appropriate. Multiple casualty incidents and use of the ICS were not new to LGMC. Their ICS had been recently tested after an outbreak of food poisoning at a local college.

Hospital Preparedness: *LGMC* first became aware of the Norris Hall incident when a call was received requesting a medical examiner. They were unable to fulfill the request. At 11:10 a.m., they received a call from Montgomery Regional Hospital advising them of the incident. LGMC immediately declared a "code aster," which is their disaster plan.

The code aster was announced throughout the hospital, the EOC was opened, and the ICS was initiated. At 11:16 a.m., they were notified that MRH was on EMS diversion. At 11:32 a.m., they were notified that they were receiving their first patient suffering from a gunshot wound. In addition to preparing for the patients to arrive at their own hospital, LGMC sent a surgeon to MRH to assist with the surge of surgical patients there.

PATIENT CARE/PATIENT FLOW/PATIENT OUTCOMES: EMS transported five patients from the Norris Hall shootings to LGMC. Table 7 lists the patient injuries and dispositions. These patients were well managed.

Table 7. Norris Hall Victims Treated by Lewis–Gale Medical Center

Injuries	Disposition
GSW grazed shoulder and lodged in occipital area, did not enter the brain	Patient taken to surgery by ENT for debridement
GSW in back of right arm, bullet not removed	Patient admitted for observation
GSW to face, bullet fragment in hair, likely secondary to shrapnel spray	Treated in ED and released
Jumped from Norris Hall, 2nd floor, shattered tib/fib	Admitted, taken to surgery the next day
Jumped from Norris Hall, 2nd floor, soft tissue injuries, neck and back sprain, reportedly was holding hands with another jumper	Treated in ED and released

Accommodation for Patients' Family and Friends: No specific information was obtained from LGMC about accommodations for patients' families and friends. However, the hospital's needs for accurate information while accommodating patient families' and friends and assisting others in attempting to locate loved ones are similar for all emergency departments in times of mass casualty incidents.

Carilion Roanoke Memorial Hospital – This Level I trauma facility located in Roanoke received three critical patients transferred from local hospitals. Two patients were transported from MRH (one from the WAJ incident and one from the Norris Hall incident). The third patient was transferred from CNRVH (from the Norris Hall incident).

HOSPITAL PREPAREDNESS: CRMH did not initiate its hospital-wide disaster plan since standard procedures allowed for effective incident management with the relatively small number of patients received. They did initiate a "gold trauma alert" that brings to the ED three nurses, one trauma attending physician, one trauma fellow physician, one radiologist, one anesthesiologist, and a lab technician.

In addition to the patient transfers, CRMH received a trauma patient from another incident. The ED had three other emergency physicians physically present with others on standby. A neurosurgeon was also in the ED awaiting the arrival of transfer patients.

CRMH's concerns echoed those of the other hospitals who received patients from the Virginia Tech incident, including lack of clarity as to expected patient surge and the need for better regional coordination. It was suggested that the RHCC Mobile Communications Unit could have been dispatched to the scene.

Patient Care/Patient Flow/Patient Outcomes: CRMH appropriately triaged and managed well the patients they received. Adequate staffing and operating rooms were immediately available. Table 8 lists WAJ and Norris Hall victims treated at CRMH.

Table 8. WAJ and Norris Hall Victims Treated by Carilion Roanoke Memorial Hospital

Injuries	Disposition
Transfer from MRH, severe head injury	Pronounced dead in ED
Transfer from MRH, head and significant facial/jaw injuries, subsequent orotracheal intubation	Patient taken to OR for surgery, subsequently transferred to a facility closer to home
Transfer from CNRVH, GSW to face, subsequent cricothyrotomy	Patient taken to OR for surgery

Carilion Roanoke Community Hospital – CRCH is a community hospital located near and associated with CRMH. CRCH treated a self-transported student who was injured by jumping from Norris Hall. Table 9 lists the injuries and disposition of this patient.

Table 9. Norris Hall Victim Treated by Carilion Roanoke Community Hospital

Injuries	Disposition
Ankle contusion and sprain secondary to jumping	Treated and released

EMERGENCY MANAGEMENT

Multicasualty incidents often require coordination among state, regional, and local authorities. This section reviews the interrelationships of these authorities.

Virginia Department of Health – In 2002, the Virginia Department of Health (VDH) was awarded funding from the Health Resources and Services Administration (HRSA) National Bioterrorism Hospital Preparedness Program (NBHPP) for enhancement of the health and medical response to bioterrorism and other emergency events. As part of this process, VDH developed a contract with the Virginia Hospital and Healthcare Association (VHHA) to manage the distribution of funds from the HRSA grant to state acute care hospitals and other medical facilities and to monitor compliance. A small percentage of the HRSA funds were used within VDH to fund a hospital coordinator position, as well as to partially fund a deputy commissioner and other administrative positions. Substantially more than 85 percent of this HRSA grant funding was distributed to hospitals or used for program enhancement, including development of a web-based hospital status monitoring system, multidisciplinary training activities, behavioral health services, and poison control centers.

At the same time, VDH received separate funding from the Centers for Disease Control and Prevention (CDC) for the enhancement of public health response to bioterrorism and other emergency events. The position of VDH Deputy Commissioner for Emergency Preparedness and Response was created, with responsibility for both CDC and HRSA emergency preparedness funds. The physician in this position reports directly to the state health commissioner, who serves as the state health officer for Virginia.[73]

The Virginia Department of Health regional planning approach aligns hospitals with health department planning regions. In collaboration with the 88 acute care hospitals in the Commonwealth, six hospital and healthcare planning regions were established, closely corresponding with five health department planning regions. Each of the six hospital planning regions has a designated Regional Hospital Coordinating Center (RHCC) located at or near the Level I trauma facility in the region as well as a regional hospital coordinator funded through the HRSA cooperative agreement.

Near Southwest Preparedness Alliance – The Near Southwest Preparedness Alliance (NSPA), which covers the Virginia Tech area, was developed under the auspices of the Western Virginia EMS Council pursuant to a memorandum of understanding between the Virginia Department of Health, the Virginia Hospital and Healthcare Association, and the NSPA. NSPA is organized to facilitate the development of a regional healthcare emergency response system and to support the development of a statewide healthcare emergency response system. Regional hospital preparedness and coordination will foster collaborative planning efforts between the several medical care facilities and local emergency response agencies in the established geographically and demographically diverse region.[74]

The "Near Southwest" region is defined as:

- 4th Planning District (New River area), which includes Floyd, Giles, Montgomery, and Pulaski counties and the City of Radford.
- 5th Planning District (Roanoke and Alleghany area), which includes Alleghany, Botetourt, Craig, and Roanoke counties as well as the cities of Covington, Roanoke, and Salem.
- 11th Planning District, which includes Amherst, Appomattox, Bedford, and

[73] Kaplowitz, L, Gilbert, C. M., Hershey, J. H., and Reece, M. D. (2007). *Health and Medical Response to Shooting Episode at Virginia Tech, April, 2007: A Successful Approach*. Unpublished Manuscript. Virginia Department of Health, p. 2.

[74] Ibid.

Campbell counties; the cities of Lynchburg and Bedford; and the towns of Altavista, Amherst, Appomattox, and Brookneal.

- 12th Planning District (Piedmont area), which includes Franklin, Henry, Patrick and Pittsylvania counties and the cities of Danville and Martinsville

The region covers 7,798 square miles and houses a population of 910,900. It has 24 local governments and 16 hospitals.

Regional Hospital Coordinating Center – At the regional level, hospital emergency response coordination during exercises and actual events is provided by RHCCs that have been established to facilitate emergency response, communication, and resource allocation within and among each of the six hospital regions. These centers serve as the contact among healthcare facilities within the region and with RHCCs in other state regions. RHCCs are also linked to the statewide response system through the hospital representative seat at the VDH Emergency Coordinating Center (ECC) in Richmond, Virginia. The hospital seat at the ECC serves as the contact between the healthcare provider system and the statewide emergency response system. It provides a communication link to the Virginia Emergency Operations Center (VEOC).[75]

The primary responsibilities of the RHCC include:

- Provide a single point of contact between hospitals in the region and the VDH ECC.
- Collect and disseminate initial event notification to hospitals and public safety partners.
- Collect and disseminate ongoing situational awareness updates and warnings, including the management of the current bed availability in hospitals.
- Establish and manage WebEOC[76] and communications systems for the duration of the incident.
- Serve as the single point of contact and collaboration point for Virginia fire/EMS agencies for the purposes of hospital diversion management, movement of patients from an incident scene to receiving hospitals, and input/guidance with respect to hospital capabilities, available services, and medical transport decisions.
- Coordinate interhospital patient movement, transfers, and tracking
- Provide primary resource management to hospitals for:
  Personnel
  Equipment
  Supplies
  Pharmaceuticals.
- Coordinate regional expenditures for reimbursement.
- Coordinate regional medical treatment and infection control protocols during the incident as needed.
- Coordinate Virginia hospital requests for the Strategic National Stockpile through the local jurisdiction EOC.

The RHCC complements but does not replace the relationships and coordinating channels established between individual healthcare facilities and their local emergency operations centers and health department officials. The regional structure is intended to enhance the communication and coordination of specific issues related to the healthcare component of the emergency response system at both regional and state levels.

At 10:05 a.m. on April 16, MRH requested that the RHCC be activated. At 10:19 a.m., it was activated under a standby status and signed on

[75] Ibid.

[76] WebEOC is a web-based information management system that provides a single access point for the collection and dissemination of emergency or event-related information

to WebEOC.[77] By 10:25 a.m., the Virginia Department of Health also had signed on to WebEOC and monitored the event. At 10:40 a.m., the RHCC requested that all hospitals provide an update of bed status and diversion status for their facility. By 10:49 a.m., LGMC was the only hospital that signed on to WebEOC of the hospitals that had received patients from the Norris Hall incident. Pulaski County Hospital also signed on and provided their status. At 11:49 a.m. (1 hour later), MRH signed on followed by CNRVH at 12:33 p.m.[78]

The WebEOC boards (the RHCC Events Board and the Near Southwest Region Events Board) were used for a variety of communications between the RHCC, hospitals, and other state agencies. Some hospitals spent considerable time attempting to post information on the WebEOC boards. None of the EMS jurisdictions signed on to either of the boards. Not all hospitals or EMS agencies are confident in using WebEOC and require regular training drills for familiarity.

The hospitals and public safety agencies should have used the RHCC and WebEOC expeditiously to gain better control of the situation. Considering the many rumors and unconfirmed reports concerning patient surge, the incident could have been better coordinated. If the RHCC was kept informed as per the MCI plan, it could have acted as the one official voice for information concerning patient status and hospital availability.

Western Virginia EMS Mass Casualty Incident Plan – The Western Virginia EMS region encompasses the 7 cities and 12 counties of Virginia Planning Districts 4, 5, and 12. The region extends from the West Virginia border to the north and to the North Carolina border to the south. The region encompasses the urban and suburban areas of Roanoke and Danville, as well as many rural and remote areas such as those in Patrick, Floyd, and Giles counties. The region's total population (based on 1998 estimates) is 661,200. The region encompasses 9,643 square miles.

The region encompasses the counties of Alleghany, Botetourt, Craig, Floyd, Franklin, Giles, Henry, Montgomery, Patrick, Pittsylvania, Pulaski, and Roanoke (Figure 21).[79]

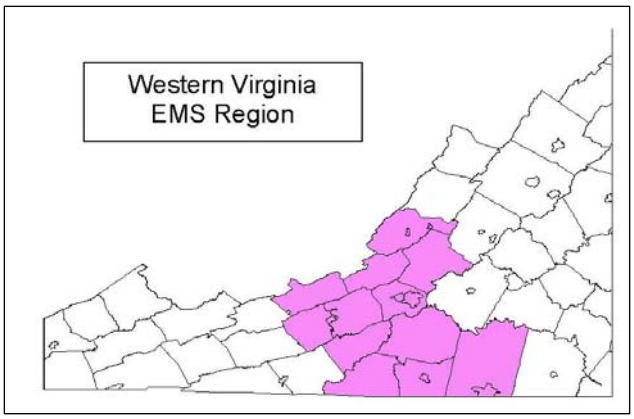


Figure 21. Map Showing Counties in the Western Virginia EMS Region[80]

Multicasualty Incidents – The Western Virginia EMS Mass Casualty Incident Plan (WVEMS MCI) plan defines a multiple casualty incident as "an event resulting from man-made or natural causes which results in illness and/or injuries that exceed the emergency medical services capabilities of a hospital, locality, jurisdiction and/or region."[81] Online medical direction is the responsibility of the MCI Medical Control, defined as:

> That medical facility, designated by the hospital community, which provides remote overall medical direction of the MCI or evacuation scene according to predetermined guidelines for the distribution of patients throughout the community.[82]

[77] Baker, B. (2007). *VA Tech 4-16-2007: RHCC Events Board*, p. 1.
[78] Baker, B. (2007). *April 16, 2007*: *Near Southwest Region Events Board,* p. 1.
[79] WVEMS. (2006). *Trauma Triage Plan*. Western Virginia EMS Council, Appendix E.
[80] Ibid.
[81] WVEMS. (2006). *Mass Casualty Incident Plan: EMS Mutual Aid Response Guide*: Western Virginia EMS Council, Section 2.1.1, p. 1.
[82] Ibid., Section 2.1.4, p. 1.

Access to online physician medical direction should be available. In MCI situations, modern EMS systems rely more on standing orders and protocols and less on online medical direction. Therefore, it may be more logical to have the RHCC coordinate these efforts, including patching in providers to online physician medical direction as needed.

The MCI plan identifies three levels of incidents based on the initial EMS assessment using the Virginia START Triage System:

- *Level 1* – Multiple-casualty situation resulting in less than 10 surviving victims.
- *Level 2* – Multiple casualty situation resulting in 10 to 25 surviving victims.
- *Level 3* – Mass casualty situation resulting in more than 25 surviving victims.[83]

The Virginia Tech incident clearly fits into the definition of a Level 3 MCI, since at least 27 patients were treated in local emergency departments.

Frustrating communications issues and barriers occurred during the incident. Every service operated on different radio frequencies making dispatch, interagency, and medical communications difficult. These issues included both on-scene and in-hospital situations that could be avoided. Specific communications challenges included the following:

- The radios used by responding agencies consisted of VHF, UHF, and HEAR frequencies. This led to on-scene communications difficulties and the inability for EMS command or Virginia Tech dispatch to assure that all units were aware of important information.
- Communications between the scene and the hospitals were too infrequent. Hospitals were unable to understand exactly what was going on at the scene. They were unable to determine the appropriate level of preparation.
- In several instances, on-scene providers called hospitals or other resources directly instead of through the ICS. This included relaying incorrect information to hospitals.
- Cell phones and blackberries worked intermittently and could not be relied upon. Officials did not have time to return or retrieve messages left on cell phones. A mobile cell phone emergency operating system was not immediately available to EMS providers.

Interviews with EMS and hospital personnel reiterated a well-known fact: face-to-face communications, when practical, is the preferred method.

From a technological standpoint, the NIMS requirement for interoperability is critical. Local communities must settle historical issues and move forward toward an efficient communications system.

Lack of a common communications system between on-scene agencies creates confusion and could have caused major safety issues for responders. Each jurisdiction having its own frequencies, radio types, dispatch centers, and procedures is a sobering example of the lack of economies of scale for emergency services. Local political entities must get past their inability to reach consensus and assure interoperability of their communications systems. In this case, the most reasonable and prudent action probably would be to expand the Montgomery County Communications System to handle all public safety communications within the county. Cooperation, consensus building, and the provision of adequate finances are required by emergency service leaders and governmental entities. Failure to accomplish this goal will leave the region vulnerable to a similar situation in the future with potentially tragic results.

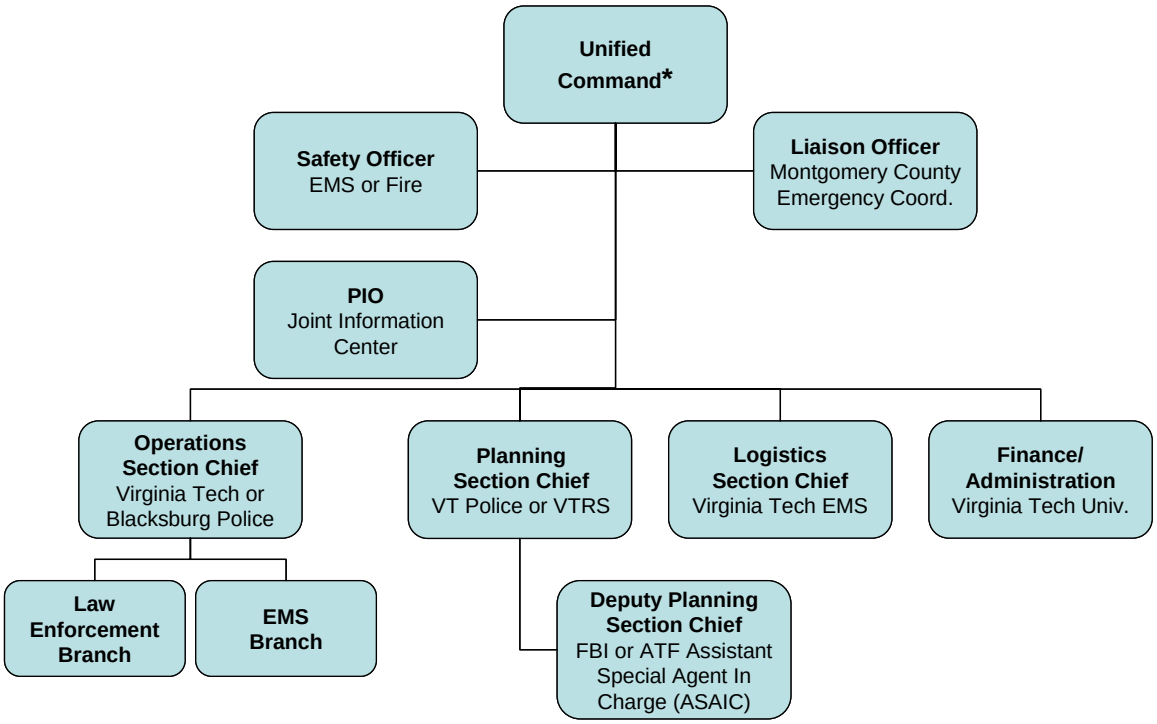
Unified Command – There is little evidence that there was a unified command structure at

[83] Ibid., Section 7, p. 4.

the Virginia Tech incident. Command posts were established for EMS and law enforcement at the Norris Hall scene and for law enforcement at another location. Separate command structures are traditional for public safety agencies. The 9/11 attack in New York City exemplified the need for public safety agencies to step back and reconsider these traditions. At Norris Hall, a unified command structure could have led to less confusion, better use of resources, better direction of personnel, and a safer working environment. Figure 22 depicts a proposed model unified command structure that could have been utilized.

The unified command post would be staffed by those having *statutory authority*. During the Virginia Tech incident, those personnel would likely have been the police chiefs for VTPD and the BPD, a university official, a VT EMS officer, a BVRS EMS officer, the FBI special agent-in-charge, the state police superintendent, and the ranking elected official for the City of Blacksburg. The operations section chief would have received operational guidelines from the unified command post and assured their implementation.

The unified command team would be in direct communications with the EOC and policymaking group. Command and general staff members would have communicated with their counterparts in the EOC. The policymaking group would have transmitted their requests to the EOC and the unified command post.


Unified Command*
Safety Officer EMS or Fire
Liaison Officer Montgomery County Emergency Coord.
PIO Joint Information Center
Operations Section Chief Virginia Tech or Blacksburg Police
Planning Section Chief VT Police or VTRS
Logistics Section Chief Virginia Tech EMS
Finance/ Administration Virginia Tech Univ.
Law Enforcement Branch
EMS Branch
Deputy Planning Section Chief FBI or ATF Assistant Special Agent In Charge (ASAIC)

*For this incident, law enforcement would have been the lead agency. The unified command post would be staffed by those having *statutory authority.* During the Virginia Tech Incident, those personnel would likely have been the police chiefs for the VTPD and BPD, a university official, a VT EMS officer, the FBI special agent-in-charge, the Virginia State Police superintendent, and the ranking elected official for the City of Blacksburg.

Figure 22. Proposed Model Unified Command Structure for an April 16-Like Incident

Emergency Operations Center – The lack of an EOC activated quickly as the incident unfolded led to much of the confusion experienced by hospitals and other resources within the community. An EOC should have been activated at Virginia Tech. The EOC is usually located at a pre-designated site that can be quickly activated. Its main goals are to support emergency responders and ensure the continuation of operations within the community. The EOC does not become the incident commander but instead concentrates on assuring that necessary resources are available.

A policy-making group would function within the EOC. Virginia Tech had assembled a policy making group that functioned during the incident.

Another responsibility of the EOC is the establishment of a joint information center (JIC) that acts as the official voice for the situation at hand. The JIC would coordinate the release of all public information and the flow of information concerning the deceased, the survivors, locations of the sick and injured, and information for families of those displaced. By not immediately activating an EOC, hospitals or the RHCC did not receive appropriate or timely information and intelligence. There was also a delay in coordinating services for families and friends of victims who needed to be identified or located. Although Virginia Tech eventually set up a family assistance center, it was not done immediately.

KEY FINDINGS

Positive Lessons

The EMS responses to the West Ambler Johnston residence hall and Norris Hall occurred in a timely manner.

Initial triage by the two tactical medics accompanying the police was appropriate in identifying patient viability.

The application of a tourniquet to control a severe femoral artery bleed was likely a life-saving event.

Patients were correctly triaged and transported to appropriate medical facilities.

The incident was managed in a safe manner, with no rescuer injuries reported.

Local hospitals were ready for the patient surge and employed their NIMS ICS plans and managed patients well.

All of the patients who were alive after the Norris Hall shooting survived through discharge from the hospitals.

Quick assessment by a hospitalist of emergency department patients waiting for disposition helped with preparedness and patient flow at one hospital.

The overall EMS response was excellent, and the lives of many were saved.

EMS agencies demonstrated an exceptional working relationship, likely an outcome of interagency training and drills.

Areas for Improvement

All EMS units were initially dispatched by the Montgomery County Communications Center to respond to the scene; this was contrary to the request.

There was a 4-minute delay between VTRS monitoring the incident (9:42 a.m.) on the police radio and its being dispatched by police (9:46 a.m.).

Virginia Tech police and the Montgomery County Communications Center issued separate dispatches. This can lead to confusion in an EMS response.

BVRS was initially unaware that VTRS had already set up an EMS command post. This could have caused a duplication of efforts and further organizational challenges. Participants interviewed noted that once a BVRS officer reported to the EMS command post, communi-

cations between EMS providers on the scene improved.

Because BVRS and VTRS are on separate primary radio frequencies, BVRS reportedly did not know where to stage their units. In addition, BVRS units were reportedly unaware of when the police cleared the building for entry.

Standard triage tags were used on some patients but not on all. The tags are part of the Western Virginia EMS Trauma Triage Protocol. Their use could have assisted the hospitals with patient tracking and record management. Some patients were identified by room number in the emergency department and their records became difficult to track.

The police order to transport the deceased under emergency conditions from Norris Hall to the medical examiners office in Roanoke was inappropriate.

The lack of a local EOC and fully functioning RHCC may lead to communications and operational issues such as hospital liaisons being sent to the scene. If each hospital sent a liaison to the scene, the command post would have been overcrowded.

A unified command post should have been established and operated based on the NIMS ICS model.

Failure to open an EOC immediately led to communications and coordination issues during the incident.

Communications issues and barriers appeared to be frustrating during the incident.

RECOMMENDATIONS

IX-1 Montgomery County, VA should develop a countywide emergency medical services, fire, and law enforcement communications center to address the issues of interoperability and economies of scale.

IX-2 A unified command post should be established and operated based on the National Incident Management System Incident Command System model. For this incident, law enforcement would have been the lead agency.

IX-3 Emergency personnel should use the National Incident Management System procedures for nomenclature, resource typing and utilization, communications, interoperability, and unified command.

IX-4 An emergency operations center must be activated early during a mass casualty incident.

IX-5 Regional disaster drills should be held on an annual basis. The drills should include hospitals, the Regional Hospital Coordinating Center, all appropriate public safety and state agencies, and the medical examiner's office. They should be followed by a formal post-incident evaluation.

IX-6 To improve multi-casualty incident management, the Western Virginia Emergency Medical Services Council should review/revise the Multi-Casualty Incident Medical Control and the Regional Hospital Coordinating Center functions.

IX-7 Triage tags, patient care reports, or standardized Incident Command System forms must be completed accurately and retained after a multi-casualty incident. They are instrumental in evaluating each component of a multi-casualty incident.

IX-8 Hospitalists, when available, should assist with emergency department patient dispositions in preparing for a multi-casualty incident patient surge.

IX-9 Under no circumstances should the deceased be transported under emergency conditions. It benefits no one and increases the likelihood of hurting others.

IX-10 Critical incident stress management and psychological services should continue to be available to EMS providers as needed.

ADDITIONS AND CORRECTIONS

(No changes from original report.)

COMMENT

One family member noted that the Report states that at 10:51 a.m. all patients from Norris Hall had either been transported to the hospital or to a minor treatment area and that at 11:40 a.m. Montgomery Regional Hospital received the last patient. The question was why it took 49 minutes to transport the last gunshot victim to the hospital.

Response: As noted in the Report, Norris Hall patients were triaged at the scene using the Simple Triage and Rapid Treatment system. The most seriously injured victims, who were denoted with a red tag as requiring immediate treatment, were transported to the hospital first. Those whose injuries were less severe (yellow tag) were attended to first at the delayed treatment unit set up at Stanger and Barger Streets and then transported to a hospital shortly afterward. This is standard, acceptable practice during a mass casualty incident. The overall EMS process received high marks from the professor of emergency medicine on the panel, and the staff member who is an instructor at the National Fire Academy on EMS management.

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Chapter X.
OFFICE OF THE CHIEF MEDICAL EXAMINER

On April 16, 2007, after the gunfire ceased on the Virginia Tech campus and the living had been triaged, treated, and transported, the sad job of identifying the deceased and conducting autopsies began. Since these were deaths associated with a crime, autopsies were legally required. The Office of the Chief Medical Examiner (OCME) had to scientifically identify each victim and conduct autopsies to determine with specificity the manner and cause of death. Autopsy reports help link the victim to the perpetrator and to a particular weapon. The OCME also has a role in providing information to victims' families.

To assess how these responsibilities were met, the panel interviewed:

- The parents and family members of the deceased victims
- Dr. Marcella F. Fierro, Chief Medical Examiner and her staff
- Colonel Steven Flaherty, Superintendent of Virginia State Police
- Mandie Patterson, Chief of the Victim Service Section, Virginia Department of Criminal Justice Services
- Jill Roark, Terrorism and Special Jurisdiction, Victim Assistance Coordinator, Federal Bureau of Investigation
- Mary Ware, Director of the Criminal Injuries Compensation Fund
- Numerous victim service providers.

The panel also reviewed the report issued by the OCME on areas for improvement, lessons learned, and recommendations.

LEGAL MANDATES AND STANDARDS OF CARE

The Office of the Chief Medical Examiner incorporates a statewide system with headquarters in Richmond and regional offices in Fairfax, Norfolk, and Roanoke. Commonwealth law requires the OCME to be notified and to investigate deaths from violence. [84]

Autopsies are used to collect and document evidence to link the accused with the victim of the crime. In the Virginia Tech cases, this was ballistic evidence—bullets and fragments of bullets. The autopsies provided scientific evidence on the types and numbers of bullets that caused the fatal injuries.

The OCME also must ensure that there is complete, accurate identification of the human remains presented for examination. When there are multiple fatalities, the possibility exists that there could be a misidentification, which would result in the release of the wrong body to at least two families. Though a rare occurrence, there are examples of this type of error in recent history. The National Association of Medical Examiners (NAME) has adopted Forensic Autopsy Performance Standards, which are considered minimal consensus standards. The most recent version was approved in October 2006. Dr. Fierro is a member of the standards committee of NAME.

The NAME standards require several procedures to be performed if human remains are presented that are unidentified. A major issue with some of the families of those who were murdered, however, was that they felt they were capable of identifying the body of their family member; in other words, from their viewpoint, the remains were not unidentifiable.

[84] Sec. 32.1-283 Investigations of deaths. Section A, Code 1950

Family members of homicide victims are generally unaware that the medical examiner is required to complete a thorough, scientific investigation in order to identify a body, determine the cause of death, and collect evidence. For the family members of victims, the experience is focused on immediacy. Is my loved one dead? When can I see my loved one? As happened at Virginia Tech, a difference in perspectives can cause deep hurt and misunderstanding. A separate matter in some of the cases was whether it was advisable for a family to view the remains.

The Virginia Tech incident presented the potential for misidentification. Bodies were presented with either inconsistent identification or none at all. This is not uncommon in mass fatality scenes due to the amount of confusion that generally exists. In order to prevent misidentification, medical examiners have established a rigorous set of practices based on national standards to ensure that identification is irrefutable. The Virginia OCME followed these standards as well as Commonwealth law in identifying the deceased.

DEATH NOTIFICATION

The death notification process is the opening portal to the long road of painful experiences and varying reactions that follow in the wake of the life-altering news that a loved one has met with death due to homicide. This news that someone intentionally murdered a family member is the critical point of trauma and often inflicts its own wounds to the body, mind, and spirit of the survivors. From a psychological and mental health perspective, trauma is an emotional wounding that affects the will to live and one's beliefs, assumptions, and values.

A homicide affects victims' families differently than other crimes due to its high-profile nature, intent, and other factors. The act of informing family members of a homicidal death requires a responsible, well-trained, and sensitive individual who can manage to cope with this mutually traumatizing experience. Family members of deceased victims have a wide range of needs and reactions to the sudden and untimely death of their loved ones. Consequently, the individuals who deliver the death notifications and the manner in which they carry out this duty factor significantly in the trauma experienced by the family. Death notifications must be delivered with accuracy, sensitivity, and respect for the deceased and their families. Ideally, death notification should be delivered in private, in person, and in keeping with a specific protocol adopted from one of the effective models.

EVENTS

Monday, April 16 – The closest OCME office to Virginia Tech is located in Roanoke. All remains from the western part of the commonwealth that require an autopsy are taken there. In addition to their full-time employees, the OCME has part-time and per-diem investigators to help conduct death investigations and refer cases to the regional offices.

The first news about the Virginia Tech shootings came to the OCME from the Blacksburg Police Department at 7:30 a.m. A police evidence technician there, who also is a per-diem employee for the ME, called to say he would not be able to attend a scheduled postmortem exam (autopsy) because there had been a shooting at the Virginia Tech campus. At this time, six cases were awaiting examination in the western regional office, an average caseload.

By 11:30 a.m., another per-diem medical examiner, who was a member of a local rescue squad, notified the regional OCME office of a multiple fatality incident at Norris Hall with upwards of 50 victims. It was at this time that one of the decedents from West Ambler Johnston (WAJ) residence hall was transported to Carillion Roanoke Memorial Hospital. The western office notified the central office in Richmond that additional assistance would be needed to handle the surge in caseload.

At 1:30 p.m., representatives from the Roanoke office arrived on campus and attended an incident management team meeting with the public

safety agencies that had responded. OCME representatives attended the operations section briefing. The activities in Norris Hall were organized by areas (classrooms and a stairway). Investigation teams of law enforcement and OCME employees were assigned specific tasks.

The OCME requested resources from the northern regional office in Fairfax and the central office in Richmond. They, along with Dr. Fierro, departed for Blacksburg by 3:00 p.m. The western office had two vacancies in forensic pathologist positions, so additional staff clearly was needed.

The first autopsy that of one of the dormitory victims, began at 3:15 p.m. No autopsy could begin until after the crime scene had been thoroughly documented and investigated. As each decedent was transported from campus, the Roanoke regional office was notified so that a case number could be assigned.

By 5:00 p.m., the first victim from Norris Hall had been transported to the Roanoke office. Volunteer rescue squads were transporting the victims from campus to the regional office, a 45-minute trip.

At 6:30 p.m., Dr. Fierro and additional staff from Richmond arrived and met with representatives from state police and the Departments of Health and Emergency Management. The methods for identification were discussed, as was the process of documenting personal effects. The last victim was removed from Norris Hall and transported to Roanoke by 8:45 p.m. By 11:30 p.m., the first autopsy was completed; identification made, next of kin notified, and the remains released to a funeral home.

Tuesday, April 17 – In the early morning hours of the first day after the shooting, additional pathologists departed the Tidewater and central regional offices for Roanoke. A staff meeting was held at 7:00 a.m. to formulate the OCME portion of the incident action plan (IAP). Key points addressed for the morgue operations sections included:

- All victims were to be forensically identified prior to release.
- A second-shooter theory was still under consideration by law enforcement. As such, all ballistic evidence had to be collected and documented. The distribution of gunshot wounds was:
  - One victim with nine
  - One victim with seven
  - Five victims with six
  - One victim with five
  - Five victims with four

The remainder of the victims had three or fewer gunshot wounds. The complexity of tracking bullet trajectories and retrieving fragments would be especially time consuming for the multiple wounds.

It was decided to use fingerprints as the primary identification method and dental records as the secondary. The reasons for this decision were:

- Fingerprints were able to be taken from all of the victims.
- Foreign students had prints on file with Customs and Border Protection.
- There was an abundance of latent prints on personal effects in dorm rooms and apartments and on personal effects recovered on site.
- The Department of Forensic Services had adequate staff available to assist in the collection and comparison of the fingerprints. (The police reported that nearly 100 law enforcement officers from local, state, and federal agencies volunteered or were assigned to assist in gathering prints and other identification.)

The alternative method for identification, dental examination, required the name of the decedent's dentist to obtain dental records, and families were asked to provide the contact information in case that method was needed.

DNA was excluded as a means of identification because the collection and processing of samples would have taken weeks.

In addition to being short-staffed by two vacancies and one injured pathologist, the ME's office had to respond to the concerns and demands of a religious group that contested one of the autopsies. By the end of the first day of operations, all of the deceased, 33, had been transported to the western region office. Thirteen postmortem examinations had been completed, two positive identifications had been made, and two families were notified and the remains released and picked up by next of kin or their representative.

Wednesday, April 18 – On the second day of morgue operations, the process of forensic identification continued. Procedures began at 7:45 a.m. and continued until 8:00 p.m.

At 10:00 a.m., the chief medical examiner gave a press conference where she discussed forensic procedures and the methods employed.

At 11:00 a.m., a representative from OCME assisted in collecting antemortem data from the families who had gathered at the family assistance center at The Inn at Virginia Tech.

"VIP" AND MISUNDERSTANDINGS: The primary form OCME uses to collect antemortem data is called a Victim Identification Protocol (VIP) form. This form, used by many medical examiners and federal response teams, documents information on hair and eye color, medical history (such as an appendectomy), and other distinguishing marks such as scars or tattoos. During a postmortem examination, the pathologist conducting the autopsy comments on his or her findings and each identifier and that information is entered into a case file. Forensic odontology (dental) and fingerprint findings may also be incorporated. Both profiles can be compared electronically and possible matches or exclusions made. The pathologist then reviews these findings as part of the scientific identification.

As case files were compiled, a designation was made as to whether a VIP form was available and included in the file. Some state officials, seeing the VIP acronym, mistakenly concluded that OCME had designated some victims as "VIPs" (very important persons), singling them out for special consideration. As it happened, several embassies did contact state officials to demand preferential treatment for their nationals who were among the victims. However, the OCME did not provide any preferential or "VIP" treatment.

*MEDIA MISINFORMATION***:** Radio station K-92 announced that the "coroner" would be releasing all of the human remains on Wednesday, April 18. The origin of this incorrect report is unknown.

TRACKING INFORMATION: At the request of the governor's office, a spreadsheet that detailed specific information for each victim was developed. During this process, members of the governor's staff became concerned that the OCME had prioritized some cases. But in fact, cases were handled without a specific plan or intent to prioritize them.

Staff members from the OCME went to the Inn to assist in the operation of the FAC. The Virginia State Police and the OCME established a process and team to notify families that their loved ones had been positively identified.

IDENTIFICATION AND VIEWING: Family members of the deceased victims were anxious for the formal identification and release of the bodies to be completed. In response to the concerns of family members regarding the length of time involved in the identification process, some state officials suggested that the families should be permitted to go to the morgue and identify the bodies if they so chose. Though this would seem reasonable, it conflicts with current practice.

A public information officer at the FAC explained to families who were assembled there what the OCME policy was regarding visible presumptive identification. Then the public information officer (PIO) unfortunately asked the families for a "show of hands" of those who

wanted to view the remains of their loved ones in case that could be arranged.

Viewing and identifying remains is a significant issue for victim survivors. Even though identification of the body by family members is not always considered scientifically reliable, for various reasons, victim survivors often want to make that decision for themselves. At Virginia Tech, families were frustrated with the lack of information from OCME and why it was taking so long to identify and release the victims' remains. Medical examiners must be sensitive to the waiting family members' need to be kept informed when there are delays and when they can expect a status update

The remains of persons killed in a crime become part of the evidence of the crime scene, and are legally under the jurisdiction of the OCME until released. The OCME can set the conditions it thinks are appropriate for the situation. The standard of care does not include presumptive identification using visual means. The public information officer who asked for a show of hands should not have done so.

When the protocol and policies of the OCME were explained to the families, some of the tension seemed to abate. The confusion and misunderstanding surrounding these issues involved misinformation, late information, no information, and the high emotional stress of the event. Had a public information officer with a background in the operations of the OCME been available or a representative from the OCME been present to answer these concerns, the controversy regarding this issue could have been reduced or eliminated.

IDENTIFICATION PROGRESS: The progress of the first day continued on the second day of morgue operations. The second-shooter theory had been discounted after it was determined forensically that Cho used two different weapons. By the end of the second day, another 20 autopsies had been completed, which meant that all 33 victims had received a postmortem exam. At this point, there were 22 total identifications and 22 remains released to next of kin. Morgue operations were conducted from 7:00 a.m. to 8:00 p.m.

Thursday, April 19 – The third day of morgue operations began at 7:00 a.m. It was determined that the OCME would work around the clock if necessary to complete the identification process this day. By this time, all of the antemortem records had arrived at the regional office.

The media had gathered in the area of the morgue and was covering the activities of representatives of the families—usually funeral homes—as they arrived to pick up the remains. Roanoke County law enforcement provided security.

All of the remaining decedents were identified and released by 6:00 p.m. The last case was a special challenge as there were no fingerprints on file and the victim did not have a dentist of record. The latent prints in the home were not readable. The identification was completed through a process of exclusion and definition of unique physical properties using the Victim Identification Protocol process. The Virginia OCME had completed 33 postmortem exams and correctly made 33 positive legal identifications within 3 working days.

Figure 23 summarizes the statistics for 3-day morgue operations. The figure shows that not all of the remains were picked up by the end of morgue operations because Cho's family did not pick up his remains for several days after the operations were shut down.

ISSUES

Three major issues surfaced during panel interviews and the collection of after-action reports in regards to the actions of the Virginia OCME; these were primarily issues presented by some families of the deceased:

- Some felt the autopsy process took too long.
- Some felt families should have been allowed to go to the morgue and visibly identify their family members.

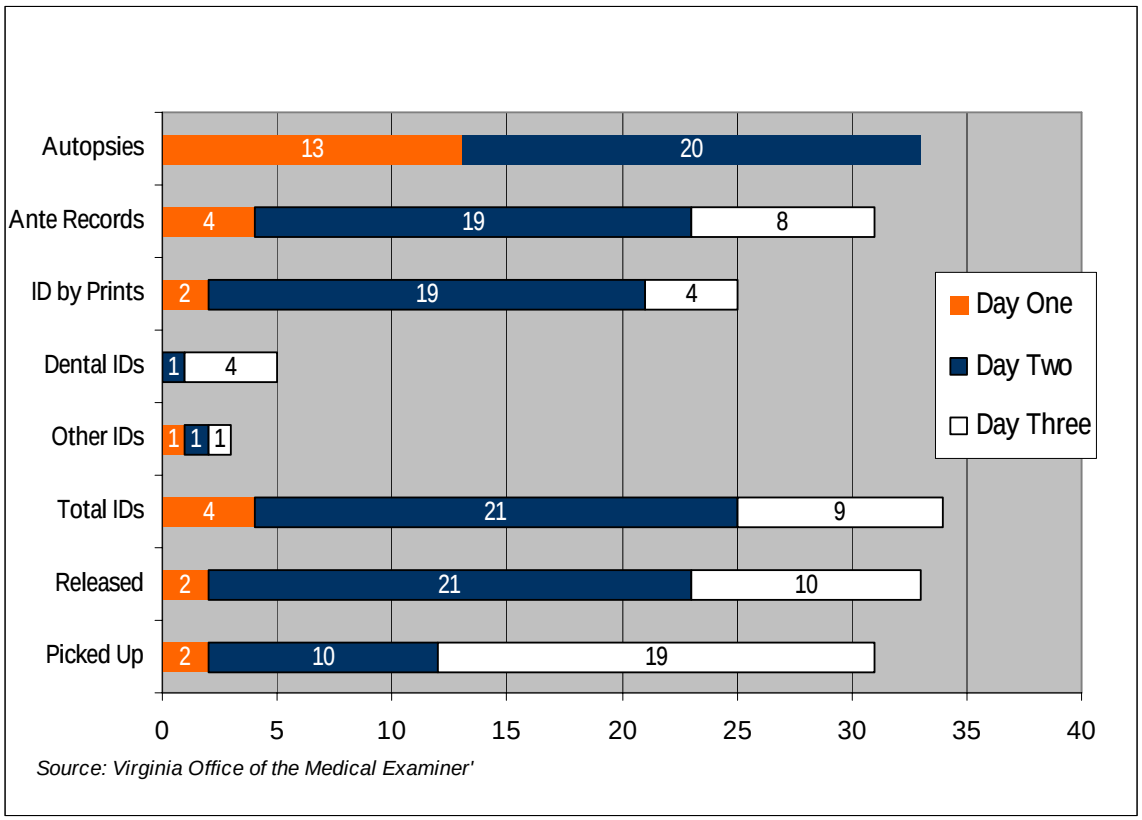

Figure 23. Progress and Activity of the OCME Over the 3-Day Period April 17–19, 2007

- Many felt the process of notifying the families and providing assistance to the families was disjointed, unorganized, and in several cases insensitive.

Speed – There is no nationally accepted time standard for the performance of an autopsy. The NAME standards mentioned earlier do not set time standards.

The average duration of the postmortem exams was just under 2 hours. Had the OCME office been fully staffed, it may have been able to perform the identifications and examinations somewhat more rapidly. The OCME did have a disaster plan that it implemented upon notification of the events. The plan called for staff from the regional and central offices to deploy to the regional office where the disaster occurred to meet the surge in caseload, which was done.

The OCME did not call for federal assistance, which is available from the Department of Health and Human Service's National Disaster Medical System (NDMS) program. That program can deploy a disaster mortuary operational response team (DMORT) composed of forensic specialists who can assist medical examiners in the event of mass fatality incidents. The DMORT system has three portable morgue units. DMORT resources (in this case, just personnel) could have been requested and probably been in place within 24 hours of mobilization.[85] For example, a DMORT was used in the Station Nightclub fire in Rhode Island in February 2003 to assist the Rhode Island medical examiner in the identification of the victims of that fire.

Once antemortem information had been gathered, DMORT personnel could have worked a second shift and might have reduced the elapsed time of morgue operations by 24 hours. Given the information regarding the performance of

[85] A member of TriData's support staff to the panel is a member of a DMORT and provided first-hand information on its operation.

the family assistance center, which also was the responsibility of OCME, this early collection may or may not have occurred. The time delay for identifications came from delays in gathering antemortem information and then providing that information to the OCME, a task outside the control of the OCME.

Identification and Viewing – The second issue was the insistence by the OCME to perform forensic identifications of the victims as opposed to presumptive identifications. Forensic identifications use methods such as fingerprinting, dental records, DNA matches, or other scientific means for identification. Presumptive identification includes photographs, driver's licenses, and visual recognition by family or friends.

Some of the families wanted to go to the regional office of the OCME to view the remains and identify the victims. The OCME did not permit this for several reasons. For one, the regional office does not have an area large enough to display all the bodies for families to view each one to determine whether it is their family member

As noted earlier, the idea of families viewing their loved one and making a legally binding identification is not the current practice of the OCME because it is not considered scientifically reliable. Nevertheless, it was emotionally wrenching for families not to have a choice in this matter. Presumptive identification is acceptable in some communities under certain conditions. OCME noted that several female victims had no personal effects such as a driver's license or student identity card when they were transported to the hospital or morgue. At the same time, some families told the medical examiner's office about specific moles, scars, or other distinguishing marks that were far more reliable than a purse and could not be confused with another victim.

A textbook for students of forensic pathology discusses the identification of human remains. Regarding the topic of reliable visual identification:

> The operative word in this method of identification is *reliable* [italics added]. Personal recognition of visage or habitus, under certain circumstances, is less reliable than fingerprints, dental data, or radiology. It (this method) relies on memory and a rapid mental comparison of physical features under stressful conditions and often a damaged body.…
>
> Another hazard in visual identification is denial. The situation may be so stressful or the remains altered by age, injury, disease or changes in lifestyle that identification is denied even if later confirmed by fingerprints or dental examination.[86]

In *Clinics in Laboratory Medicine*, Victor Weedn writes:

> Visual recognition is among the least reliable forms of identification. Even brothers, sisters and mates have misidentified victims. …Family members may find it emotionally difficult and uncomfortable to carefully gaze at the dead body, particularly a loved one. Identification requires a rapid mental comparison under stressful conditions. The environment in which the identification is made and the appearance of the person at death are unnatural and strange.…[87]

Family Treatment – The third issue was the treatment of the families of the decedents regarding official notification and support while waiting for positive identification. Their treatment was haphazard, inconsistent, and compounded the pain and trauma of the event.

Victims of crime are afforded a number of rights, among them the right to be treated with dignity and respect. The right of respect speaks to victims being given honest and direct information free of any attempt to protect them from perceived emotional injury or their inability to process information. Crime victims rights are protected by federal and state laws. Basic rights

[86] Spitz and Fisher, *Medicolegal Investigation of Death,* 3rd edition, Edited by Werner U. Spitz. 1993, pages 77–78.
[87] Victor Weedn, "Postmortem Identification of Remains," *Clinics in Laboratory Medicine*, Volume 18, March 1998, page 117.

for victim survivors generally include the right to be notified and heard, and to be informed.

In 1996, following several airline accidents, the families of the victims felt the airline companies and government officials did not address their needs, desires, or expectations. In that year, Congress passed the Aviation Disaster Family Assistance Act. This law holds airline companies and government officials, such as medical examiners and coroners, accountable to the National Transportation Safety Board for compassionate, considerate, and timely information regarding the disposition of their loved ones or next of kin.

The U.S. Department of Justice, through its Office of Justice Programs, has an Office for Victims of Crime (OVC) that can provide support for victims of federal crimes such as terrorism.

To this end, many medical examiners' offices have developed plans for the establishment of family assistance centers. A FAC serves several purposes. First, it is the location where families can receive timely, accurate, and compassionate information from officials. Second, medical examiner's office staff can collect vital antemortem information from families there to assist in the positive identification of the deceased. Third, it can be the location where private, compassionate notification of the positive identification of the deceased can be conducted with next of kin.

A FAC was established in Oklahoma City in April 1995 following the Murrah Building bombing. Families were notified in private, before the media was notified. This model for the compassionate, accurate information exchange was published by the federal OVC.[88]

Although a FAC was established at The Inn at Virginia Tech, reports received by the panel indicate that what was provided was not adequate. Many complaints were lodged by families regarding what they perceived as an insensitive attitude and manner of communication from the medical examiner's office. Some families also objected to the rigid application of the scientific identification process. Among the complaints and questions relevant to the ME functions were the following:

- Inadequate communication efforts (lack of information).
- Lack of sensitivity to the emotions of survivors.
- Lack of a central point of contact for information for responders, victims, and family members.
- Lack of a security plan that resulted in an inability to distinguish personnel, responding service providers, and other agents with authority to enter the FAC and surrounding areas.
- Confusion regarding the Victim Identification Profile form.
- Confusion regarding the identification process as to length and method used and its necessity.
- Failure to provide adequate isolation for parents in receiving information.
- Location of the media relative to the FAC; media management in general was lacking.
- Issues surrounding the source and responsibility for death notifications.
- Lack of personnel trained, skilled, and prepared to assist victims upon receipt of death notification.
- Concern that no one was addressing the needs of all family members, and awareness that some family members were having great difficulty in coping.
- No timely or consistent family briefings.
- Confusion about who is responsible for the death notifications and family assistance.

[88] OVC, "Providing Relief After a Mass Fatality, Role of the Medical Examiners Office and the Family Assistance Center," Blakney, 2002

Some of these complaints are associated with the medical examiner's office, but others are not. In fact, no one individual agency or department of government is charged with the responsibility of organizing and maintaining a fully operational family assistance center. This is an oversight in federal and state policies. Existing planning guidance, such as the National Response Plan, parcels out pieces of the FAC function to various lead agencies, but places no one agency in charge. The OCME is clearly identified as being responsible for fatality management, including death notifications; also, the state plan calls for OCME to set up a family victim identification center within the FAC. Who is supposed to run the FAC is not addressed.

The university attempted to provide these services. In the Virginia Tech Emergency Operations Plan, the Office of Student Programs is responsible to:

> Develop and maintain, in conjunction with the Schiffert Health Center, Cook Counseling Center, the University Registrar, and Personnel Services, procedures for providing mass care and sheltering for students, psychological and medical support services, parental notification and other procedures as necessary,[89]

A university the size of Virginia Tech must be prepared for more than emergencies of limited size and scope. Universities need plans for major operations. If the situation dictates the need for additional help from outside the university, then all concerned must be prepared to proceed in that direction.

The university turned to the state for help on Wednesday, April 17. It should have done so earlier. The *Commonwealth Emergency Operations Plan* in its "Emergency Support Function (ESF)" #8" addresses public health and fatality issues. The Health Department is the lead agency for this ESF. The OCME mass fatality plan is found in Volume #4, "Hazardous Materials and Terrorism Consequence Management Plan," part 14-D-2.

The OCME plan considers 12 or more fatalities in 1 day in one regional office to be the trigger point for implementation of the emergency plan. The plan calls for the establishment of both a family assistance center and a family victim identification center. At this location, the OCME and law enforcement agencies would conduct interviews to gather antemortem information and notify next of kin. The OCME, however, does not have sufficient personnel to perform this task, and its plan indicates as much (page 16). To their credit, the OCME has recruited a team of volunteers through the Virginia Funeral Directors Association to assist in the operation of a FAC. Funeral directors by training and disposition have experience in interactions with bereaved families. This group is an ideal choice to provide assistance to the OCME. Unfortunately, this team was not available for the Virginia Tech incident because the state requires background checks and ID cards for these teams and funding was not provided for them.

What evolved by Wednesday, April 18, was an uncoordinated system of providing family support. It was too late and inadequate.

KEY FINDINGS

Positive Lessons

The part of the OCME disaster plan related to postmortem operations functioned as designed. The internal notification process as well as staff redeployments allowed the surge in caseload generated by the disaster to be handled appropriately as well as existing cases and other new cases that were referred to the OCME from other events statewide.

Thirty-three positive identifications were made in 3 days of intense morgue operations.

The contention that the OCME was slow in completing the legally mandated tasks of investigation is not valid.

[89] "VA Tech Emergency Response Plan," Appendix 10 to Functional Annex A, page 45.

Crime scene operations with law enforcement were effective and expedient.

Cooperation with the Department of Forensic Services for fingerprint and dental comparison was good.

The OCME performed their technical duties well under the pressures of a high-profile event.

Areas for Improvement

The public information side of the OCME was poor and not enough was done to bring outside help in quickly to cover this critical part of their duties. The OCME did not dedicate a person to handle the inquiries and issues regarding the expectations of the families and other state officials. This failure resulted in the spread of misinformation, confusion for victim survivors, and frustrations for all concerned.

The inexperience of state officials charged with managing a mass fatality event was evident. This could be corrected if state officials include the OCME in disaster drills and exercises.

The process of notifying family members of the victims and the support needed for this population were ineffective and often insensitive. The university and the OCME should have asked for outside assistance when faced with an event of this size and scope.

Training for identification personnel was inadequate regarding acceptable scientific identification methods. This includes FAC personnel; Virginia funerals directors; behavioral health, law enforcement, public health, and public information officials; the Virginia Dental Association; and hospital staffs.

Adequate training for PIOs on the methods and operations of the OCME was lacking. This training had been given to two Health Department public information officers prior to the shootings. However, since neither was available, information management in the hands of an inexperienced public information officer proved disastrous. This in turn, allowed speculation and misinformation, which caused additional stress to victims' families.

No one was in charge of the family assistance center operation. Confusion over that responsibility between state government and the university added to the problem. Under the current state planning model, the Commonwealth's Department of Social Services has part of the responsibility for family assistance centers. The university stepped in to establish the center and use the liaisons, but they were not knowledgeable about how to manage such a delicate operation. Moreover, the university itself was traumatized.

RECOMMENDATIONS

The following recommendations reflect the research conducted by the panel, after-action reports from Commonwealth agencies, and other studies regarding fatality management issues.

X-1 The chief medical examiner should not be one of the staff performing the post-mortem exams in mass casualty events; the chief medical examiner should be managing the overall response.

X-2 The Office of the Chief Medical Examiner (OCME) should work along with law enforcement, Virginia Department of Criminal Justice Services(DCJS), chaplains, Department of Homeland Security, and other authorized entities in developing protocols and training to create a more responsive family assistance center (FAC).

X-3 The OCME and Virginia State Police in concert with FAC personnel should ensure that family members of the deceased are afforded prompt and sensitive notification of the death of a family member when possible and provide briefings regarding any delays.

X-4 Training should be developed for FAC, law enforcement, OCME, medical and mental health professionals, and others

regarding the impact of crime and appropriate intervention for victim survivors.

X-5 OCME and FAC personnel should ensure that a media expert is available to manage media requests effectively and that victims are not inundated with intrusions that may increase their stress.

X-6 The Virginia Department of Criminal Justice Services should mandate training for law enforcement officers on death notifications.

X-7 The OCME should participate in disaster or national security drills and exercises to plan and train for effects of a mass fatality situation on ME operations.

X-8 The Virginia Department of Health should continuously recruit board-certified forensic pathologists and other specialty positions to fill vacancies within the OCME. Being understaffed is a liability for any agency and reduces its surge capability.

X-9 The Virginia Department of Health should have several public information officers trained and well versed in OCME operations and in victims services. When needed, they should be made available to the OCME for the duration of the event.

X-10 Funding to train and credential volunteer staff, such as the group from the Virginia Funeral Director's Association, should be made available in order to utilize their talents. Had this team been available, the family assistance center could have been more effectively organized.

X-11 The Commonwealth should amend its Emergency Operations Plan to include an emergency support function for mass fatality operations and family assistance. The new ESF should address roles and responsibilities of the state agencies. The topics of family assistance and notification are not adequately addressed in the National Response Plan (NRP) for the federal government and the state plan that mirrors the NRP also mirrors this weakness. Virginia has an opportunity to be a national leader by reforming their EOP to this effect.

A FINAL WORD

The weaknesses and issues regarding the performance of the OCME and the family assistance process that came to light in the aftermath of the Virginia Tech homicides did not reveal new issues for this agency. In July 2003, the Commonwealth published "Recommendations for the Secure Commonwealth Panel." Appendix 1-3 of this report addressed mass fatality issues. Although the intent of the report was to assess the state of preparedness in Virginia for terrorist attacks, many of the issues that arose following the Virginia Tech homicides were identified in this report. Had the recommendations in this report been implemented, many of the problems cited above might have been averted.

Therefore, the panel also recommends that the recommendations found in Appendices 1-3 of the Secure Commonwealth Panel from 2005 be implemented.

ADDITIONS AND CORRECTIONS

(No changes from original report.)

Chapter XI.
IMMEDIATE AFTERMATH AND THE LONG ROAD TO HEALING

In the hours, days, and weeks following Cho's calculated assault on students and faculty at Virginia Tech, hundreds of individuals and dozens of agencies and organizations from Virginia Tech, local jurisdictions, state government, businesses, and private citizens mobilized to provide assistance. Once again the nation witnessed the sudden, unexpected horror of a large number of lives being intentionally destroyed in a fleeting moment. Only those caught up in the immediate moments after the attacks can fully describe the confusion, attempts to protect and save lives, and the heartbreaking struggle to recover the dead. Reeling from shock and outraged by the shootings, students and faculty who survived Norris Hall and law enforcement officers and emergency medical providers who arrived on the scene will carry images with them that will be difficult to deal with in the months and years ahead.

Disaster response organizations including community-based organizations, local, state and federal agencies, and volunteers eager to help in any capacity flooded the campus. The media descended on the grounds of Virginia Tech with a large number of reporters and equipment, pursuing anyone and everyone who was willing to talk in a quest for stories that they could broadcast across the nation to feed the public's interest in the shocking events.

The toll of April 16, 2007, assaults the senses: 32 innocent victims of homicide, 26 physically injured, and many others who carry deep emotional wounds. For each, there also are family members and friends who were affected. Each of the 32 homicides represents an individual case unto itself. The families of the deceased as well as each physically and emotionally wounded victim have required support specific to their individual needs. Finding resolution, comfort, peace, healing, and recovery is difficult to achieve and may take a lifetime for some.

The people whose lives were directly affected include:

- Family members of the murdered victims, who are often called co-victims due to the tremendous impact of the crimes on their lives.
- Physically and emotionally wounded victims from Norris Hall and their family members who, while grateful that they or their loved ones were spared death, face injuries that may have a profound effect upon them for a lifetime.
- Witnesses and those within a physical proximity to the event and their family members.
- Law enforcement personnel who faced life-threatening conditions and were the first to respond to Norris Hall and among the first to respond to West Ambler Johnston dormitory. They encountered a scene few officers ever see. Their families are not sparred from the complicated impact of the events.
- Emergency medical responders who treated and transported the injured. Their family members also share in the complexity of reactions experienced by emergency medical responders.
- Everyone from Virginia Tech who was part of the immediate response to the two shooting incidents and the aftermath that followed.
- Mental health professionals.
- Funeral home personnel and hospital personnel, who, while accustomed to traumatic events, are not necessarily spared the after-effects.
- Volunteers and employees from surrounding jurisdictions and state agencies, and others who worked diligently to

provide support in the first hours and days.

- The campus population of students, faculty, and staff and their families.

This chapter describes the major actions that were taken in the aftermath of April 16. Many other spontaneous, informal activities took place as well, especially by students. For example, members of the Hokie band went to the hospitals and played for some injured students outside their windows. The madrigal chorus from Radford University sang at a memorial service for several students who had been killed. The private sector made donations and offered assistance. It is difficult to capture the true magnitude of the heartfelt responses and the special kindnesses exhibited by thousands of people.

At the time of publication of this report, recovery was only 4 months along in a process that will continue much longer. The following sections discuss the actions that key responders and entities took in the immediate aftermath of the shootings and during the weeks that followed.

FIRST HOURS

After Cho committed suicide and the scene was finally cleared by the police to allow EMS units to move in, the grim reports began to emerge. The numbers of dead and injured rose as each new report was issued. Parents, spouses, faculty, students, and staff scrambled for information that would confirm that their loved ones, friends, or colleagues were safe. They attempted to contact the university, hospitals, local police departments, and media outlets, in an attempt to obtain the latest information.

Chaos and confusion reigned throughout the campus in the immediate aftermath. Individuals and systems were caught unaware and reacted to the urgency of the moment and the enormity of the event. There was an outpouring of effort to help and to provide for the safety of everyone. Responders scrambled to offer solace to the despairing and to meet emergency needs for medical care and comfort to the injured. These initial spontaneous responses helped to stabilize some of the impact of the devastation as it unfolded.

Grief-stricken university leaders, faculty, staff, and law enforcement worked together to monitor the rapidly changing situation and set up a location where families could assemble. Some family members arrived not knowing whether their child, spouse, or sibling had been taken to a hospital for treatment for their wounds, or to a morgue. University officials designated The Inn at Virginia Tech as the main gathering place for families.

ACTIONS BY VIRGINIA TECH

The immediate tasks were to provide support to the families of Virginia Tech students and particularly to the family members of the slain and injured. Countless responders including law enforcement officers, concerned volunteers, government entities, community-based organizations, victim assistance providers, faculty, staff, and students worked diligently to lend assistance in this uncharted territory, the impact of a mass murder of this scale. Many aspects of the post-incident activities went well, especially considering the circumstances; others were not well handled.

The incident revealed certain inadequacies in government emergency response plan guidelines for family assistance at mass fatality incidents. Also, certain state assistance resources were not obligated quickly enough and arrived late. Finally, the lack of an adequate university emergency response plan to cover the operation of an onsite, post-emergency operations center (and most particularly a joint information center) and a family assistance center hampered response efforts.

A variety of formal and informal methods were used to assist surviving victims and families of deceased victims.

University-Based Liaisons – The Division of Student Affairs organized a group of family liaisons, individuals who were assigned to two or

more families for the purpose of providing direct support to victim survivors. The liaison staff was comprised of individuals from the Division of Student Affairs, the graduate school, and the Provost's Office. They were tasked to track down and provide information to families of those killed and to victim survivors, to assist them with the details of recovering personal belongings and contacting funeral homes, and to act as an information link between families and the university. Liaisons worked out the details on such matters as transportation, benefits from federal and state victim's compensation funds (as that information became available), coordination with the Red Cross, travel arrangements for out-of-country relatives, and much more. They also helped arrange participation in commencement activities where deceased students received posthumous degrees.

Interviews with victims' families revealed that many of the liaisons were viewed as sensitive, knowledgeable, caring, and helpful. Originally set up as a temporary resource for the early days and weeks following the shootings, the liaisons soon discovered that the overwhelming needs and expectations for their assistance would be ongoing. Many liaisons continued to help even as the weeks stretched on, while others were not in a position to continue on at such an intense level for an extended period of time. Still others were not prepared to serve in the capacity of a liaison and lacked training and skills needed to provide assistance to crime victims.

There were a few reports of poor communication, insensitivity, failure to follow-up, and misinformation, which added to the confusion and frustration experienced by a number of families. Largely, these problems occurred because Liaisons were volunteers untrained in responding to victims in the aftermath of a major disaster. Nevertheless, they were willing and available to fill an acute need while system based victim
assistance providers awaited the required invitation before they were authorized to respond to Virginia Tech campus. The liaisons themselves had little if any experience in dealing with the aftermath of violent crime scenes and were grappling with their own emotional responses to the deaths and injuries of the students and faculty. Liaisons did not have adequate information on the network of services designed for victims of crime until at least 2 days later when most of the state's victim assistance team arrived.

In general, most families reported that their liaisons were wonderful and conscientious, and they were grateful for the tremendous amount of time and effort put forth by them on their behalf.

State Victims Services and Compensation Personnel – Assistance to survivor families and families of the injured could have been far more effective if executed from the beginning as a dual function between university-assigned liaisons and professional victim assistance providers working together to meet the ongoing needs of each family

Victim assistance programs throughout the nation are supported by federal, state, and local governments. Many victim assistance programs are community based and specific to domestic violence and sexual assault crimes, while other programs are system-based and operate out of police departments, prosecutor's offices, the courts, and the department of corrections. These programs provide crisis intervention, counseling, emotional support, help with court processes, links to various resources, and financial assistance to victims of crime. They represent a network of trained, skilled professionals accustomed to designing programs and strategies to meet the specific needs of crime victims. Moreover, all states have a victim compensation program charged with reimbursing crime victims for certain out-of-pocket expenses resulting from criminal victimization.

Patricia Snead, Emergency Planning Manager at the Virginia Department of Social Services (DSS), alerted Mandie Patterson, Chief of the Commonwealth's Victim Services Section (VSS) at the Department of Criminal Justice Services (DCJS), at 12:21 p.m. on April 16, and asked that office to stand by for possible mobilization to

support the needs at Virginia Tech. At that point, it was unclear whether DCJS staff from Richmond or local advocates would be needed to staff a family assistance center and whether Virginia Tech would request assistance for these services per the state's emergency management procedures. According to those procedures, before VSS staff can move forward, they must be authorized to do so from DSS. There was no further instruction that day from DSS.

The following day, April 17, the DCJS chief of VSS sent a broadcast e-mail to the 106 victim witness programs in Virginia to determine the availability of advocates with experience in working with victims of homicide. At 4:17 p.m. that day, DSS sent a message to DCJS, VSS and the victim advocates from local sister agencies indicating that they were authorized to respond to the needs of victims on the campus. The team of victim service providers arrived on April 18, 2 days after the massacre. Thus, even though the Commonwealth's emergency plan authorizes immediate action, the process moved slowly—a real problem given the substantial need for early intervention, crisis response, information and help in establishing the family assistance center. According to Snead, time was lost while officials from the state and the university worked through the question of who was supposed to be in charge of managing the emergency and its aftermath: the state university or the state government. Reportedly, the university was guarded and initially reluctant to accept help or relinquish authority to the Commonwealth for managing resources and response.

Mary Ware, Director of the Department of Criminal Injuries Compensation Fund (CICF), arrived on Tuesday around midnight. Early on Wednesday morning, she began providing the services of her office and talked to two on-scene staff from the Montgomery County Victim Witness Program. Kerry Owens, director of that program, told the panel, "You have never seen such pain, sorrow, and despair in one place, and you have never seen so many people come together for a common cause." The CICF provides funds to help compensate victim survivors with medical expenses, funeral and burial costs, and a number of other out-of-pocket expenses associated with criminal victimization. At Virginia Tech, CICF enabled the rapid provision of funds to cover funeral expenses, temporarily setting aside certain procedures until they could be processed at a later date. CICF staff and the team of victim service providers orchestrated by DCJS arrived on Wednesday morning and proceeded to help in various capacities.

The delay in the mobilization and arrival of the victim service providers resulted in some families working directly with the medical examiner regarding that office's request for personal items with fingerprints or DNA samples to help identify the bodies. Though the university liaisons were helping, a number of families did not have the benefit of a professional victim service provider to support them in coping with the ME's requests. Many families had scattered and begun making arrangements with funeral homes, which had a direct line to the ME's office. Other nongovernmental service providers—many without identification or a security badge—appeared on the scene without having been summoned to help. As a consequence, some families received conflicting information about what the Red Cross would pay for, what the state would cover, and what they would have to manage on their own.

The victim assistance team comprised of the state's two relevant agencies—DCJS and CICF—had difficulty locating and identifying victim survivors. Victim Services and Crime Compensation staff became aware that the United Way was fund-raising on campus and sought out those individuals to ensure that there were no conflicts or duplications of effort. The victim assistance team provided assistance for family members by informing them of their rights as crime victims and offering assistance in a number of areas to include help with making funeral arrangements, childcare in some instances, arranging for transportation, emotional support and referral information. Unfortunately, when many of the family members returned home to other states or other parts of Virginia, they were not connected directly to available services in

their local jurisdictions. Because of the need to respect privacy and confidentiality, victim assistance providers in the victims' hometowns had to refrain from intruding and instead had to await invitation or authorization by others to become linked to the families. There was a gap in the continuum of care as, in many cases, survivors returned home with little or no information regarding ongoing victim services in their jurisdictions. To the extent the liaisons had sufficient information about victim's assistance services to tell the families, they did. However, unless the liaison or other responsible on-scene providers provided families and victims with specific information regarding their local victim services office, they did not know what services were available or how to access them.

The Family Assistance Center – The Inn at Virginia Tech became the *de facto* information center and gathering place where everyone congregated to await news on the identification of the wounded and deceased. It also was designated as a family assistance center—a logical choice for families who needed lodging, information, and support. Accommodations at the inn (rooms, food, and staff service) were well received, and hotel staff offered special care to the families who stayed there. However, the sheer magnitude of the immediate impact coupled with the failure to establish an organized, centralized point of information at the outset resulted in mass confusion and a communications nightmare that remained unabated throughout the week following the shootings.

The official Virginia Tech FAC was set up in one of the ballrooms at Skelton Conference Center at the Inn. Over the first 36 hours, 15 victim advocates from several victim assistance programs arrived and formed a victim assistance team comprised of seven staff from the Office of CICF and other service providers and counselors. Additionally, staff from the Office of the Chief Medical Examiner (OCME) was assigned to supervise the family identification section (FIS) at the FAC. The FIS, according to the OCME Fatality Plan "will receive inquiries on identification, prepare Victim Identification Profiles, and collect any materials, records, or items needed for confirmation of identification.

A FAC also is supposed to serve as a safe haven, a compassion center, and a private environment created to allow victims and surviving family members' protection from any additional distress brought about as a result of intrusive media. In addition to serving as an information exchange mechanism, the FAC affords victims and family member's refreshments, access to telephones for long-distance calls, and support from mental health counselors and victims' service providers.

Arriving media, unfortunately, were situated in a parking lot directly across from the inn. Families had to traverse a labyrinth of cameras and microphones to reach the front desk at the inn. The media were a constant presence because they were stationed in the same area rather than at a site farther away on Virginia Tech's large campus. The impact of the media on victim survivors is enormous. In high-profile murder cases the murderer instantaneously is linked to the victims and together become household names. Some members of the press were appalled at the tactics that some of their colleagues used to gather information on campus at the family assistance center.

There was little organization and almost no verifiable information for many hours after the shooting ended. The operative phrase was "go to the inn" but once there, families struggled to know who was responsible for providing what services and where to go for the latest news about identification of the dead victims. Some unidentified people periodically asked families if they needed counseling. Those offers were premature in the midst of a crisis and information was the most important thing that families wanted at the time.

Family members were terrified, anxious, and frantic to learn what was happening. Who had survived? Which hospital was caring for them? Where were the bodies of those who had perished taken and how can one get there? There was no identified focal point for information distribution for family members or arriving support staff. For

decades, disaster plans have underscored the importance of having a designated public information officer (PIO) who serves as the reliable source of news during emergencies. The PIO serving at the FAC was inexperienced and overwhelmed by the event. He was unable to adequately field inquires from victim survivors. Help from the state arrived later, but here again, repairing the damage caused by misinformation or no information at all became all but impossible.

Guests at the inn, officials from state government, and others reported a chaotic scene with no one apparently in charge. From time to time, small groups of families were pulled aside by law enforcement officials or someone working in public information to hear the latest information, leaving other families to wonder why they could not hear what was happening and what the information might mean for their own relative whose condition was in question. A number of victim families eventually gave up hope of learning the status of their spouse, son, or daughter and returned home.

Without a formal public information center, adequately staffed, the ability to maintain a steady stream of updates, control rumors, and communicate messages to all the families at the same time was seriously hampered. Here is where advance planning for major disasters provides jurisdictions with a template and a fighting chance to appropriately manage the release of information.

The university did establish a 24-hour call center where volunteers from the university and staff from the Virginia Department of Emergency Management responded to an enormous volume of calls coming into the school.

Two of the most deeply disturbing situations were the dearth of information on the status and identification of Cho's victims and the instances where protocol for death notifications was breached. The authority and duty for this grim task falls usually to law enforcement, hospital emergency room personnel, and medial examiner offices. Victim advocates, clergy, or funeral directors ideally accompany law enforcement during a death notification. Reports are that law enforcement, where involved, conducted sensitive and caring death notifications to family members.

Virginia State Police officers, in some instances with local law enforcement, personally carried the news no one wants to hear to victims' homes around Virginia late into the night of the 16th. Officers also coordinated with law enforcement in other states who then notified the families in those jurisdictions. Not all families, however, were informed in that manner. One family learned their child was dead from a student. In another case, a local clergy member took it upon himself to inform a family member that their loved one was dead while they were on an elevator at the Inn. The spouse of a murdered faculty member saw members of the press descend on her home before his death had been confirmed.

The victims were known to faculty and friends across campus. As a result, information circulated quickly through an informal network, which allowed a few family members, who lived in the immediate area and who arrived quickly at the inn, to connect with those who were helping to locate the missing. Families who lived out of the area had to rely on the telephone to obtain information. Lines were busy and connections were clogged. They were referred from one number to another as they tried to track down information that would confirm or deny their worst fears.

Until Friday, April 20, families reported that they had to think of what questions to ask and then try to locate the right person or office to answer the question. The intensity of their pain and confusion would have been diminished somewhat if they had received regular briefings with updates on the critical information sought by all who were assembled at the inn. It would have helped if there had been a point person through whom questions were channeled. The liaisons and the victim assistance team did the best they could, but for the most part they were in the dark as well.

To make room for all the individuals who needed to stay at the inn, many resource personnel like Virginia State Police and others were housed in dormitories at nearby college campuses like Radford University.

Counseling and Health Center Services – The university's Cook Counseling Center quickly led efforts to provide additional counseling resources and provide expanded psychological assistance to students and others on campus. They extended their hours of operation and focused special attention on individuals who lived at the West Ambler Johnston dormitory, surviving students, who were in Norris Hall at the time of the incident, roommates of deceased students, and classmates and faculty in the other classes where the victims were enrolled. The victims had participated in various campus organizations, so Cook Counseling reached out to them as well. Dozens of presentations on trauma, post-incident stress, and wellness were made to hundreds of faculty, staff, and student groups. The center helped make referrals to other mental health and medical support services. The center sent 50 mental health professionals to the graduation ceremonies several weeks later, recognizing that the commencement would be an exceptionally difficult time for many people. Resource information on resilience and rebounding from trauma was developed and distributed, including posting on the Internet.

Schiffert Health Center at the university sent medical personnel to the hospitals where injured victims were being treated to check on their well being and reassure them of follow-up treatment at Schiffert if needed. The medical personnel included some psychological screening questions into their conversations with the injured students so that they could monitor the student's psychological state as well.

Other University Assistance – The Services for Students with Disabilities Office began investigating classroom accommodations that might be needed for injured students and planned for possible needs among students with psychological disabilities. The Provost's Office announced flexible options for completing the semester and for grading. The college deans, the faculty, and Student Affairs were helpful in advising students and helping them complete the semester. Academic suspensions and judicial cases were deferred.

Cranwell International Center provided complimentary international telephone cards to students who needed to contact their families abroad and assure them they were safe. Center staff called each Korean undergraduate and many Korean graduate students and, with the Asian American Student Union and Multicultural Programs and Services, assured each one of the university's concern for their safety. They especially addressed potential retaliation and requests from the press.

Residence Life asked resident advisors to speak personally with each resident on campus and make sure they were aware of counseling services as they grappled with lost friends or roommates. Housing and Dining Services provided complimentary on-campus meals for victims' families and friends at graduation. Several of the victims were graduate students at Virginia Tech. The graduate school helped open the multipurpose room in the Graduate Life Center as a place for graduate students to gather and receive counseling services. They also aided graduate assistants in continuing their teaching and research responsibilities.

Hokies United is a student-driven volunteer effort that responds to local, national, and international tragedies. In addition to a candlelight vigil, this group organized several well-attended activities designed to bring the campus community together.

Human Resources requested assistance from the university's employee assistance provider, which sent crisis counselors immediately. The counselors worked with faculty and staff on issues of self-care, recovery, how to communicate the tragedy to their children, and other subjects. After 4 weeks, more than 125 information sessions had been held and 800 individuals had been individually counseled.

MEETINGS, VISITS, AND OTHER COMMUNICATIONS WITH FAMILIES AND WITH THE INJURED

President Steger, Governor Kaine, and Attorney General McDonnell visited injured students in area hospitals to reassure them of the university's and the Commonwealth's concern for their recuperation. President Steger also met with many families over the following weeks. Governor Kaine held a private meeting with families who were dealing with the death of their child, husband, or wife and another meeting with injured students and their families.

On April 19 Governor Kaine appointed the Virginia Tech Review Panel to examine the facts surrounding April 16. After appointment, panel chairman Gerald Massengill sent a letter to all families of the deceased to express condolences and offer to meet with anyone who wished a private audience with up to two members of the panel. (As noted in Chapter I, FOIA rules require that such meetings be public if more than two members participate.) The letter also offered them the opportunity to speak at one of the four public meetings that were to be scheduled in different parts of the state. Several families took advantage of a special web site that was created as a tool for collecting information and comments. Others communicated their thoughts through letters. The chairman sent a similar letter to injured students.

Over the next several weeks, a number of families communicated their desire to meet. Others preferred their privacy, which of course was respected. Panel members and staff held at least 30 meetings (in individual and group sessions) with families of the murdered victims and with injured students and their parents, and fielded more than 150 calls. The governor designated Carroll Ann Ellis as the panel's special family advocate. She spent many days initiating and returning calls to provide information and to help families regarding their individual issues and concerns. Many with whom the panel met or talked with by phone noted appreciation for the assistance and support they had received and for the work of the panel.

Several families raised concerns about poor coordination—what they saw as failings of the university, of responders, of communicators, of volunteers, of the panel and staff, and more. Some demanded financial restitution; most focused on relating what society had lost with those 32 lives, who by all measures were outstanding individuals whose achievements and character were making a difference in the world. The families asked the panel and the Commonwealth to find out what went wrong and change what needs to be changed so others might be spared this horror. That has been the overriding concern of the governor and of the panel.

Family members of homicide victims of mass fatalities tend to view their experiences and the impact of the crime from the following perspectives:

- *The overwhelming event and the system response to the scale of the event*. Very often, the victims become categorized as a group rather than as individuals (e.g., 9/11 and Oklahoma City victims). The particular needs of each victim can be overlooked as the public perceives them as a unit rather than as separate families. Victims are attuned to whether they received the information and care attention that they needed. Victim survivors want to know what happened, how it happened, and why their loved was killed. They look for resources that can adequately respond to their needs and answer their questions, though some answers may never be found.
- *Death notifications have long-term impact on victims*. Survivors typically remember the time, place, and manner in which they first learned of the death of their loved ones.
- *Where is the justice?* Victim survivors look to the criminal justice system to hold the murderer accountable for the crime. Cho ended his life and denied the

criminal justice system and its participants the justice that comes from a conviction and eventual sentencing.

A homicide differs from other types of death because it—

- Is intentional and violent.
- Is sudden and unexpected.
- Connects the innocent victim to the murderer in a relationship that is disturbing to family members of the dead victim.
- Creates an aura of stigma that surviving family members often experience.
- Is a criminal offense and as such is associated with the criminal justice system.
- It has the problematic overlap of symptoms created by the victim survivor's inability to move through the grief process because of a preoccupation with the trauma experience cause by a homicidal death. This completed grief reaction is identified as traumatic grief.
- Is pursued by the media and is of interest to the public.

Meeting the overwhelming needs of the families of homicide victims and fulfilling those expectations to a level each one finds acceptable is extremely challenging when there is a mass murder. So many people need the same information and services simultaneously. Systems are severely tested because disasters cause the breakdown of systems and create chaos. Without a well-defined plan, navigating through the aftermath is an uphill struggle at best. Even when plans are in place, the quality and degree of response to victims of disaster are often inconsistent. A small change in the initial conditions of a sensitive system can drastically affect the outcome.

All deaths generate feelings of anger, rage and resentment. In the case of a murder, and especially when the shooter commits suicide, survivors are denied their day in court and the opportunity for the justice system to hold that person accountable. This adds insult to the terrible injury they already are experiencing. In these cases, accurate information in real time is imperative if survivors are to develop a sense of trust in the very systems they now must count on to explain what happened, and why it happened. When for a variety of reasons that does not occur, relatives of homicide victims can experience increased trauma.

Each family has its own particular way of processing the death of a loved one, because each life taken was unique. Several grievances, however, were shared widely among the victims' families as well as questions they wanted the panel's investigation to address. Among the major concerns and questions were the following:

- What are the facts and details of the first responder and university response to the first shooting, including the decision process, timing, and wording of the first alert?
- What were the assumptions regarding the relationship between the first two victims, and why were they made?
- Did those assumptions affect the nature and timeliness of the subsequent first alert?
- What are the facts and details of the first responder and university response when the shooting at Norris Hall began?
- With so many red flags flying about Cho over a protracted period of time, how was it that he was still living in the dorm and allowed to continue as a student in good standing? Why were the dots not connected?
- Was Cho's family notified of any or all of his interactions with campus police, the legal system, and the mental hospital?
- Why was there no central point of contact or specific instructions for families of victims at The Inn at Virginia Tech?
- Why were identifications delayed when wallet identifications, photos, and other methods available would hasten the release of remains?

- Who was responsible for ensuring that the media was properly managed, and who was supposed to be the authoritative source of information?
- What is going to be done with the Hokie Fund and what about other crime compensation funds?
- What common sense practices regarding security and well being will be in place before students return to campus?
- What changes to policy and procedures about warnings have been made at Virginia Tech?

These and many other issues all have been examined by the panel and the results presented throughout this report.

With regard to the individuals who Cho injured— physically and emotionally—their wounds may take a long time to heal if they ever can heal completely. Many of the men and women who were in the classrooms that Cho attacked and who survived, bravely helped each other to escape, called for help, and barricaded doors. Others were too severely wounded to move. These men and women in Norris Hall not only witnessed the deaths of their colleagues and professors, but on a physical and emotional level also experienced their dying. The terror of those who survived Cho's attacks in the classrooms was increased by the silence of death as the living harbored somewhere between life and death. Exposure to such an overwhelmingly stressful event quite often leads to post traumatic stress disorder (also known as critical incident stress) represented by an array of symptoms that range from mild to severe and which are not always immediately apparent.

The law enforcement officers and emergency medical providers who were the first to witness the carnage, rescue the living, and treat and transport the physically wounded were exposed to significant trauma. Their healing also is of concern.

CEREMONIES AND MEMORIAL EVENTS

People seek ways to share their grief when tragic events occur. The university community came together in many ways, from small prayer groups to formal ceremonies and candlelight vigils. Cassell Coliseum was the site of convocation on Tuesday, April 17. President George Bush, Governor Tim Kaine, University President Charles Steger, noted author and Professor Nikki Giovanni, and leaders from four major religions spoke to a worldwide television audience and 35,000 people in attendance divided between the coliseum and Lane Stadium. Perhaps the most poignant event, however, was the student-organized candlelight vigil later that evening. One by one, thousands of candles were lit in quiet testimony of the shared mourning that veiled every corner of the campus. Stones were placed in a semicircle before the reviewing stand to honor the victims of the previous day's shooting. Mourners wrote condolences and expressed their grief on message boards that filled the area, while flowers, stuffed animals, and other remembrances were left in honor of the professors and students who died in a dorm room and in classrooms.

VOLUNTEERS AND ONLOOKERS

Disasters draw an enormous response. At Virginia Tech, hundreds of volunteers came to offer their services; others arrived in unofficial capacities to promote a particular cause, and many drove to Virginia Tech to share the grief of their friends and colleagues. As occurs during many disasters, some special interest groups with less than altruistic intentions arrived in numbers and simply took advantage of the situation to promote their particular cause. One group wore T-shirts to give the impression they were bona fide counselors when their main goal was to proselytize. Others wanted to make a statement for or against a particular political position.

Legitimate resources can be a great asset if they can be identified and directed appropriately. An emergency plan should define where volunteers

should report and spells out procedures for registration, identification, and credentialing. That way, available services can be matched to immediate needs for greater effectiveness.

COMMUNICATIONS WITH THE MEDICAL EXAMINER'S OFFICE

With regard to identifying the victims, everything was done by the book and with careful attention to exactness as described in Chapter X. Therein, however, lay the crux of a wrenching problem for the families. From a clinical perspective, the ME's office can be credited with unimpeachable results. From a communications and sensitivity perspective, they performed poorly.

A death notification needs to be handled so that families receive accurate information about their loved one in a sensitive manner and in private with due respect. The OCME should have taken into consideration the wishes of the family and their care and safety once the news was delivered. Counseling services need to be available to families during the process of recovering the remains. The media needs to be managed with reference to families and their right to privacy, dignity, and respect. Finally, victims' families need to be given explanations for any delays in official notifications and then be provided crisis support in the wake of receiving that news.

For example, families needed to know what method was being used to identify their loved one, and when and how the personal effects would be retuned. Some families were told that identification would take 5 days and were given no explanation why. Some families did not understand why autopsies had to be performed. Some wondered about getting copies of the ME's reports and how they could obtain those. The ME's office attached this information to each death certificate, but they concur this may not have been sufficient.

DEPARTMENT OF PUBLIC SAFETY

Many families interviewed by the panel praised Virginia Secretary of Public Safety John Marshall and the efforts of the Virginia State Police during the days following the murders. Marshall's leadership coalesced resources at the scene. The state police, with some help from campus police, mobilized to assist the medical examiner. They collected records and items from homes to help confirm the identities of the deceased and they carried official notification of death to the families. State troopers also provided security at The Inn at Virginia Tech to prevent public access to the FAC.

Finally, in the aftermath of April 16, the panel has discerned no coordinated, system-wide review of major security issues among Virginia's public universities. With the exception of the Virginia Community College System, which immediately formed an Emergency Preparedness Task Force for its 23 institutions, the responses of the state-supported colleges and universities appear to be uncoordinated.

While Governor Kaine covered a large conference on campus security August 13, to the panel's knowledge, there have been no meetings of presidents and senior administrators to discuss such issues as guns on campus, privacy laws, admissions processes, and critical incident management plans. The independent colleges and universities met collectively with members of the panel, and the community colleges have met them twice. The presidents of the senior colleges and universities declined a request to meet with members of the panel June 26, saying it was "not timely" to do so.

KEY FINDINGS

Mass fatality events, especially where a crime is involved, present enormous challenges with regard to public information, victim assistance, and medical examiner's office operations. Time is critical in putting an effective response into motion.

Discussions with the family members of the deceased victims and the survivors and their family members revealed how critical it is to address the needs of those most closely related to victims with rapid and effective victim services and an organized family assistance center with carefully controlled information management Family members of homicide victims struggle with two distinct processes: the grief associated with the loss of a loved one and the wounding of the spirit created by the trauma. Together they impose the tremendous burden of a complicated grieving process.

Post traumatic stress is likely to have affected many dozens of individuals beginning with the men and women who were in the direct line of fire or elsewhere in Norris Hall and survived, and the first responders to the scene who dealt with the horrific scene.

While every injured victim and every family members of a deceased victim is unique, much of what they reported about the confusion and disorganization following the incident was similar in nature.

Numerous families reported frustration with poor communications and organization in the university's outreach following the tragedy, including errors and omissions made at commencement proceedings.

A coordinated system-wide response to public safety is lacking. With the exception of the Virginia community College System, which immediately formed an Emergency Preparedness Task Force for its 23 institutions, the response of the state-supported colleges and universities has been uncoordinated. To the panel's knowledge, there have been no meetings of presidents and senior administrators to discuss such issues as guns on campus, privacy laws, admissions processes, and critical incident management plans. The independent colleges and universities met collectively with members of the panel, and the community colleges have met with panel members two times. The presidents of the senior colleges and universities declined a request to meet with members of the panel June 26, saying it was "not timely" to do so.

RECOMMENDATIONS

The director of Criminal Injuries Compensation Fund and the chief of the Victim Services Section (Department of Criminal Justice) conducted internal after-action reviews and prepared recommendations for the future based on the lessons that were learned. The recommendations with which the panel concurred are incorporated into the following recommendations.

XI-1 Emergency management plans should include a section on victim services that addresses the significant impact of homicide and other disaster-caused deaths on survivors and the role of victim service providers in the overall plan. Victim service professionals should be included in the planning, training, and execution of crisis response plans. Better guidelines need to be developed for federal and state response and support to local governments during mass fatality events.

XI-2 Universities and colleges should ensure that they have adequate plans to stand up a joint information center with a public information officer and adequate staff during major incidents on campus. The outside resources that are available (including those from the state) and the means for obtaining their assistance quickly should be listed in the plan. Management of the media and of self-directed volunteers should be included.

XI-3 When a family assistance center is created after a criminal mass casualty event, victim advocates should be called immediately to assist the victims and their families. Ideally, a trained victim service provider should be assigned to serve as a liaison to each victim or victim's family as soon as practical. The victim service should help victims navigate the agencies at the FAC.

XI-4 Regularly scheduled briefings should be provided to victims' families as to the status of the investigation, the

identification process, and the procedures for retrieving the deceased. Local or state victim advocates should be present with the families or on behalf of out-of-state families who are not present so that those families are provided the same up-to-date information.

XI-5 Because of the extensive physical and emotional impact of this incident, both short- and long-term counseling should be made available to first responders, students, staff, faculty members, university leaders, and the staff of The Inn at Virginia Tech. Federal funding is available from the Office for Victims of Crime for this purpose.

XI-6 Training in crisis management is needed at universities and colleges. Such training should involve university and area-wide disaster response agencies training together under a unified command structure.

XI-7 Law enforcement agencies should ensure that they have a victim services section or identified individual trained and skilled to respond directly and immediately to the needs of victims of crime from within the department. Victims of crime are best served when they receive immediate support for their needs. Law enforcement and victim services form a strong support system for provision of direct and early support.

XI-8 It is important that the state's Victims Services Section work to ensure that the injured victims are linked with local victim assistance professionals for ongoing help related to their possible needs.

XI-9 Since all crime is local, the response to emergencies caused by crime should start with a local plan that is linked to the wider community. Universities and colleges should work with their local government partners to improve plans for mutual aid in all areas of crisis response, including that of victim services.

XI-10 ***Universities and colleges should create a victim assistance capability either in-house or through linkages to county-based professional victim assistance providers for victims of all crime categories. A victim assistance office or designated campus victim advocate will ensure that victims of crime are made aware of their rights as victims and have access to services.***

XI-11 In order to advance public safety and meet public needs, Virginia's colleges and universities need to work together as a coordinated system of state-supported institutions.

ADDITIONS AND CORRECTIONS

University-appointed Liaisons: p. 136, Correction – Each liaison assigned by Virginia Tech had one or more families to assist, not two or more.

Appendix B.
INDIVIDUALS INTERVIEWED BY RESEARCH PANEL

(Revised, with corrections to some names and titles.)

The Virginia Tech Review Panel conducted more than 200 interviews. The interviewees included family members of victims; injured victims; students; and individuals from universities, law enforcement, hospitals, mental health organizations, courts, and schools. During the course of the review, the interviews were conducted in person, through public meetings, by phone, and through group meetings. A number of people were interviewed multiple times.

The panel wishes to express its appreciation to everyone who graciously provided their time and comments to this undertaking.

In 2009 several changes were made to this list to correct titles and spellings of some names. , and to reflect preferences for how some are listed.

Virginia Tech	
Carl Bean	English Department Faculty
Cathy Griffin Betzel	Cook Counseling Center
Erv Blythe	Vice President for Information Technology
Tom Brown	Dean of Students
Sherry K. Lynch Conrad	Cook Counseling Center
Fred D'Aguilar	English Department Faculty
Ed Falco	English Department Faculty
Christopher Flynn, PhD.	Director, Cook Counseling Center
David R. Ford	Vice Provost for Academic Affairs
Nikki Giovanni	English Department Faculty
Kay Heidbreder	University Counsel
Bob Hicok	English Department Faculty
Zenobia Lawrence Hikes	Vice President for Student Affairs
Lawrence G. Hincker	Associate Vice President for University Relations
Maggie Holmes	Office Manager, West Ambler Johnston Hall
Jim Hyatt	Vice President and Chief Operating Officer
Frances Keene	Director, Judicial Affairs
Gail Kirby	Associate Vice President for Student Affairs
Judy Lilly	Associate Vice President
Heidi McCoy	Director of Administrative Operations, News and External Relations
Jim McCoy	Capital Design and Construction
Lenwood McCoy	Liaison of University President to Panel
Jennifer Mooney	Coordinator Undergraduate Counseling
Jerome Niles	Dean, College of Liberal Arts and Human Sciences
Lisa Norris	English Department Faculty
Lynn Nystrom	Director, News and External Relations, College of Engineering (faculty in Norris Hall)
Ishwar Puri	Chairman, Engineering Mechanics Dept. (faculty in Norris Hall)
Kerry J. Redican	President, Faculty Senate

Lucinda Roy	Past Chair, English Department
Carolyn Rude	Chair, English Department
Joe Schetz	Aerospace and Ocean Engineering Faculty
Maisha Marie Smith	Cook Counseling Center
Ed Spencer	Associate Vice President for Student Affairs
Charles Steger	President
Other Universities and Colleges	
Richard Alvarez	Chief Financial Officer, Hollins University
Grant Azdell	College Chaplain, Lynchburg College
Mary Ann Bergeron	Virginia Community Services Board
Walter Bortz	President, Hampden-Sydney College
William Brady, MD	University of Virginia, Department of Emergency Medicine
William Thomas Burnett, MD	Medical Director of the Virginia State Police Div 6 SWAT Team
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Pamela Fox	President, Mary Baldwin College
Ken Garren	President, Lynchburg College
Nancy Gray	President, Hollins University
Robert B. Lambeth	President, Council of Independent Colleges in Virginia
Robert Lindgren	President, Randolph-Macon College
Greg McMillan	Executive Assistant to President, Emory and Henry College
Katherine M. Loring	Vice President for Administration, Virginia Wesleyan College
Courtney Penn	Special Assistant to the President, Roanoke College
Herb Peterson	Vice President for Business and Finance, University of Richmond
Richard Pfau	President, Averett University
Jeff Phillips	Director of Administrative Services, Ferrum College
Michael Puglisi	President, Virginia Intermont College
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James C. Renick	Senior Vice President, American Council on Education
Robert Satcher	President, Saint Paul's College
LeeAnn Shank	General Counsel, Washington and Lee University
Wesley Shinn	Dean, Appalachian School of Law
Douglas Southard	Provost, Jefferson College of Health Sciences
Phil Stone	President, Bridgewater College
Loren Swartzendruber	President, Eastern Mennonite University

Melvin C. Terrell	Vice President of Student Affairs, Northeastern Illinois University
Madelyn Wessel	Special Advisor/Liasion to the General Counsel and Chair, Psychological Assessment Board, University of Virginia
William Woods, MD	Department of Emergency Medicine, University of Virginia
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National Higher Education Associations	
Robert M. Berdahl	President, Association of American Universities
George R. Boggs	President and CEO, American Association of Community Colleges
Susan Chilcott	Vice President for Communications, American Association of State Colleges and Universities
Charles L. Currie	President, Association of Jesuit Colleges and Universities
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James C. Renick	Senior Vice President, American Council on Education
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Law Enforcement	
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Joey Albert	Captain, Virginia Tech Police Department
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David Cardona	Special Agent-in-Charge, FBI Criminal Division (NY)
Rick Cederquist	Counter-Terrorism Coordinator, Union County (NJ) Sheriff's Office
Don Challis	Chief, College of William and Mary Police Department
Kim Crannis	Chief, Blacksburg Police Department
Lenny Depaul	U.S. Marshal's Service (NY/NJ), Fugitive Task Force
Robert C. Dillard	Chief, University of Richmond Police Department and President, Virginia Association of Chiefs of Police
Jonathan Duecker	Assistant Commissioner, New York Police Department
Chuck Eaton	Special Agent, Salem, VA, Virginia State Police
Samuel Feemster	Supervisory Special Agent for the FBI, Behavioral Science Unit
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Wendell Flinchum	Chief, Virginia Tech Police Department
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Vincent Giardani	New York Police Department Counter-Terrorism Division
Michael Gibson	U. Va Chief of Police
Christopher Giovino	SES Resources/Dempsey Myers Co.

Ray Harp	SWAT Team Commander and Homicide Detective, Arlington County (VA) Police Department (ret.)
Charles Kammerdener	New York Police Department, Special Operations Division
Robert Kemmler	Lt. Col., Virginia State Police; Deputy Director, Bureau of Administration and Support Service
Kenneth Lanning	Supervisory Special Agent for the FBI (ret.)
Jeff Lee	Active Shooter Training Program, International Tactical Officers Organization
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George Marshall	New York State Police
Raymond Martinez	New York Police Department Counter-Terrorism Division
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Dennis Schnur	Chairman, Police Foundation of Nassau County Inc.
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Anthony Wilson	Sergeant, Emergency Response Team, Blacksburg Police Department
Jason Winkle	President, Active Shooter Training Program, International Tactical Officers Organization

Joan Yale	Nassau County, New York Police Department
Families of Victims	
Ms. Lynnette. Alameddine	Mother of Ross Alameddine
Stephanie Hofer	Wife of Christopher James Bishop
Mr. and Mrs. Dennis Bluhm	Parents of Brian Roy Bluhm
Mr. and Ms. Cloyd	Parents of Austin Michelle Cloyd
Mrs. Patricia Craig	Aunt to Ryan Christopher Clark
Ms. Betty Cuevas	Mother of Daniel Alejandro Perez
Mrs. Linda Granata	Wife of Kevin P. Granata
Mr. Gregory Gwaltney	Father of Matthew Gregory Gwaltney
Marian Hammaren and Chris Foote	Mother and Stepfather of Caitlin Millar Hammaren
Mr. John Hammaren	Father of Caitlin Millar Hammaren
Mr. Michael Herbstritt	Father of Jeremy Michael Herbstritt
Mr. and Mrs. Eric Hilscher	Parents of Emily Jane Hilscher
Mrs. Tracey Lane	Mother of Jarret Lee Lane
Mr. Jerzy Nowak	Husband of Jocelyne Couture-Nowak
Mr. William O'Neil	Father of Daniel Patrick O'Neil
Mrs. Celeste Peterson	Mother of Erin Nicole Peterson
Mr. and Mrs. Larry Pryde	Parents of Julia Kathleen Pryde
Mr. and Mrs. Peter Read	Parents of Mary Karen Read
Mr. and Mrs. Joseph Samaha	Parents of Reema Joseph Samaha
Mrs. Holly Adams-Sherman	Mother of Leslie Geraldine Sherman
Mr. Girish Suratkal	Brother of Minal Hiralal Panchal
Mr. and Mrs. Paul Turner	Parents of Maxine Shelly Turner
Ms. Liselle Vega-Coates Ortiz	Wife of Juan Ramon Ortiz
Mr. and Mrs. White	Parents of Nicole Regina White
Cho Family	
Mr. and Mrs. Cho	Parents of Seung Hui Cho
Sun Cho	Sister of Seung Hui Cho
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Injured Victims and Their Families	
Alec Calhoun	Student, Virginia Tech
Colin Goddard	Student, Virginia Tech
Suzanne Grimes	Mother of Kevin Sterne
Emily Haas	Student, Virginia Tech
Mrs. Lori Haas	Mother of Emily Haas

Jeremy Kirkendall	Virginia National Guard
Mrs. Miller	Mother of Heidi Miller
Erin Sheehan	Student, Virginia Tech
Rescue Squads	
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William W. Booker IV	Virginia Tech Rescue Squad
Charles Coffelt	Carilion Patient Transportation Services
Paul Davenport	Carilion Patient Transportation Services
Jeremy Davis	Virginia Tech Rescue Squad
Jason Dominiczak	Virginia Tech Rescue Squad
Kevin Hamm	Christiansburg Rescue Squad
Matthew Johnson	Captain, Virginia Tech Rescue Squad
Tom Lovejoy	Blacksburg Volunteer Rescue Squad
Alisa Nussman	Virginia Tech Rescue Squad
John O'Shea	Blacksburg Volunteer Rescue Squad
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Mike Hill	Director, Emergency Department, Montgomery Regional Hospital
Scott Hill	Chief Executive Officer, Montgomery Regional Hospital
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Judith M. Kirkendall	Administrator, Criminal History Records, Richmond, VA
David Linkous	Director, Staff Development and Emergency Management, Montgomery Regional Hospital
Rick McGraw	Carilion Roanoke Memorial Hospital Emergency Room

William Modzeleski	Assistant Deputy Secretary, U.S. Department of Education
John O'Shea	Lieutenant and Cardiac Technician, Blacksburg Volunteer Rescue Squad
Fred Rawlins, DO	Carilion New River Valley Medical Center
Mike Turner	Clinical Support Representative, Carilion St. Albans
Holly Wheeling, MD	Montgomery Regional Hospital
Federal, State, and Local Agencies	
Marcella Fierro, MD	Chief Medical Examiner, VA
Robert Foresman	Director of Emergency Management, Rockbridge County, VA
Mandie Patterson	Chief Victim Service Section, Department of Criminal Justice Services, VA
Patricia Sneed	Emergency Planning Manager, Virginia Department of Social Services
Jessica Stallard	Assistant Director, Victim Services, Montgomery County, Virginia
Karen Thomas	Virginia Department of Criminal Justice Services
Mary Ware	Director, Criminal Injuries Compensation Fund
Mental Health Professionals	
Harvey Barker, MD	Director of Crisis and Intervention, New River Community Service Board
Richard Bonnie	Director, Institute of Law, Psychiatry and Public Policy, University of Virginia
Gail Burruss	Director, Adult Clinical Services and Crisis Intervention, Blue Ridge Behavioral Healthcare
Pam Kestner Chappalear	Executive Director, Council of Community Services
Lin Chenault	Executive Director, New River Community Service Board
Katuko T. Coelho	Center for Multicultural Human Services
Roy Crouse	Independent Evaluator for Commitment
Joan M. Ridick Depue	Clinical Psychologist, Pastoral Counseling, Culpeper, VA
Russell Federman	Director, Counseling and Psychological Services, University of Virginia
Kathy Godbey	New River Community Service Board, pre-screener for commitment
James Griffith, MD	Psychiatrist, Center for Multicultural Human Services
Kathy Highfield	Blue Ridge Behavioral Healthcare
Dennis Hunt	Executive Director, Center for Multicultural Human Services
D. J. Ida	Clinical Psychologist and Executive Director, National Asian American and Pacific Islander Mental Health Association
Jerald Kay , MD	Chair, College Mental Health Committee for the American Psychiatric Association, Chair of the Department. of Psychiatry, Wright State School of Medicine
Wun Jung Kim, MD	Psychiatrist and Professor, University of Pittsburgh
Jeanne Kincaid	ADA/OCR , Attorney with Drummond Woodson
Francis Lu, MD	Chair, APA Council on Minority Mental Health and Health Disparities, Professor of Clinical Psychiatry, UCSF

James Madero	Clinical Psychologist, Former NIMH Staff/School Violence Specialist, California School of Professional Psychologists at Alliant International University
Kent McDaniel, MD	*Consultant Psychiatrist to the Office of the Inspector General, VA*
Jasdeep Migliani, MD	Staff Psychiatrist, St Albans Medical Center, Carilion Health System
Frank Ochberg, MD	Former Director of Michigan Department of Mental Health
Carrie Owens	Director of Victim Services, Montgomery County, VA
Annelle Primm, MD	Director, Division of National and Minority Affairs, American Psychiatric Association
Andres Pumariega, MD	Chair of the Diversity Committee for the American Psychiatric Association, Chair Department of Psychiatry, Reading Hospital, PA
James S. Reinhard	Commissioner, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Gregory B. Saathoff, MD	Executive Director, Critical Incident Analysis Group, University of Virginia
Les Saltzberg	Executive Director, New River Community Service Board
Jim Sikkema	Executive Director, Blue Ridge Behavioral Healthcare
Bruce Smoller, MD	President-elect, Medical Association of Maryland; HPC
James W. Stewart III	Inspector General, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Terry Teel	Attorney for Commitment
Clavitis Washington-Brown	Blue Ridge Behavioral Healthcare
Richard West	Psychologist, Research on Preventing Campus Mental Health-Related Incidents
Courts/Hearing Officials	
Paul Barnett	Special Justice
Donald J. Farber	Attorney at Law, San Rafael, CA
Lorin Costanzo	Special Justice, Virginia
John Molumphy	Special Justice, Virginia
Joseph Graham Painter	Attorney, Former Special Justice
High School Staff	
Dede Bailer	Director, Psychology and Preventative Services, Fairfax County Public Schools
Rita Easley	School Guidance Counselor, Westfield High School
Frances Ivey	Former Assistant Principal, Westfield High School
Students at Virginia Tech	
Joseph Aust	Cho Roommate
Chandler Douglas	Resident Advisor
John Eide	Cho Roommate
Andy Koch	Cho Suitemate
Austin Morton	Cho Resident Advisor

Melissa Trotman	Resident Advisor
Business	
Kathleen Schmid Koltko-Rivera	President, Professional Services Group, Winter Park, FL
Mark E. Koltko-Rivera	Executive Vice President, Professional Services Group, Winter Park, FL
Other	
Steve Capus	President, NBC News
Steven Erickson	Father of Stalking Victim
Mr. Gibson	Father of Stalking Victim
David McCormick	Vice President, NBC News
Luke Van Heul	Former Member, Delta Force